



**KING COUNTY, WASHINGTON STATE,
SAFE AND BRIGHT FUTURES PROJECT**

NEEDS ASSESSMENT REPORT FOR INFANTS, CHILDREN, AND YOUTH EXPOSED TO DOMESTIC VIOLENCE

December 2006



AND COMMUNITY PARTNERS

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Glossary of Terms

The following is a list of terms used in this document and their intended definitions.

“Child Maltreatment” is defined as physical abuse, sexual abuse or neglect of a child that constitutes a clear and present danger to a child’s health, welfare or safety.

“Children” are defined as all infants, children, and adolescents ages birth to eighteen years.

“Children Exposed to Domestic Violence” is defined as children who are present when acts of domestic violence occurs with their caregivers and/or other intimate partners. This includes hearing or seeing domestic violence events or being in the same location where domestic violence events occur.

“Domestic Violence”¹ is defined as “a pattern of assaultive and coercive behaviors, including physical, sexual and psychological attacks, as well as economic coercion, that adults or adolescents use against their intimate partners^{1”}.

“Domestic Violence Perpetrator” or ***“Domestic Violence Abuser”*** means a person who inflicts acts of domestic violence onto their intimate partners

“Domestic Violence Survivor” means a person who is being abused by their intimate partner.

“DV” means domestic violence.

¹ Washington State Gender and Justice Commission (2002). Domestic Violence Manual for Judges.

Safe and Bright Futures Project Needs Assessment

Executive Summary

Background and Project Purpose

President Bush created the *Safe and Bright Futures for Children's Initiative* in 2004 to support strategic planning regarding infants, children, and youth's exposure to domestic violence (DV). King County was awarded one of twenty-two nationwide grants. Public Health – Seattle & King County, in full partnership with the King County Judicial Administration and their community partners, conducted a needs assessment and wrote a strategic plan. The purpose of this document is to report the project's needs assessment findings. The needs assessment project was important first step in developing a sustainable comprehensive county system of care for infants, children and youth exposed to DV.

The project design and management teams identified several data sources, including demographic data from King County regional profiles, Year 2000 Census, estimates on number of children exposed to violence, reports, local surveys, and community service data. Additional qualitative data were collected from focus groups and interviews with adults and teens who had experienced DV as children, and mothers whose children had experienced DV.

Highlights and Key Findings from Safe and Bright Futures Needs Assessment

Demographic Profile of King County Children

- 390,646 children under 18 years of age are living in King County. Of all children living in King County, 43% are in South County; 26% in East County; 23% in Seattle and 8% in North County.
- Approximately 39,064 to 78,129 children and youth living in King County are exposed to DV yearly, based on national estimates and 2000 US Census data. It is also estimated that 128,913 King County children and youth have been exposed to DV sometime during their childhood or adolescent years.

King County Services Data

- At the time of referral to CPS, approximately 47% of families have indications of DV at the time of referral. Based on this percentage, 2,415 King County families with approximately 3,687 children were referred to CPS with indications of DV in 2004.
- King County Office of the Prosecuting Attorney's Protection Order Advocacy Program Statistics (2004) indicated that 63% of families served (1,691 families with 2,879 children) included children on protection orders.

- Family Court Services (FCS) of King County Superior Court completed 289 DV-related family assessments in 2004. Many of the children were quite young: 47% (135) were birth-five years; 36% (106) were 6-11 years, and 17% (48) were 12-18 years. FCS completed 392 parenting plan assessments involving 572 children and youth. Of these family assessments, 49% (192) involved findings of DV.
- Community-based DV programs provided services to over 2,400 households in 2004. Of these households, 76% had children.

DV survivors and professional service providers meetings, surveys, interviews, and focus groups findings

One: Close the service gaps for children and their families

- ***There is a lack of specialized services for children affected by DV.*** Expand advocacy, direct services and other supports that would be tailored to meet the diverse needs of children. Provide longer-term services and supports. Ensure that families are aware of programs and can provide linkages to them. Make sure that mental health services are available and that providers have the needed expertise to serve children, especially for very young children, ages birth to five years of age. Recognize that many families lack sufficient resources or medical insurance benefits for mental health services.
- ***Children need opportunities to learn more and talk about DV.*** Many who spoke with us referenced school settings as good opportunities to provide learning and discussion. They said that more DV support groups are needed in community settings. Children and youth need to learn that DV is not OK and that it is not their fault.
- ***Parents need support to strengthen family relationships.*** Parents need guidance and support on how best to talk about DV experiences with children. Parents and children need services to support and strengthen their relationships with each other.
- ***Children need informal networks and activities that build resiliency.*** Children require a range of supports, activities, and services that strengthen their natural support networks and break family isolation. Parents would like their children to have positive experiences outside the home, such as after school programs, tutoring, sports, dance classes and art activities that would help improve their self esteem and make them strong.
- ***There is a lack of culturally relevant DV services.*** Providers asked that more services be provided that accommodate the unique cultural and language needs of DV survivors and their children.
- ***More basic support services are needed.*** Such supports include increased access to housing, transportation, and legal services.
- ***Increase and improve the services for battering parents.*** More work is needed to help increase DV batterers' understanding on effects of their abusive behaviors on their

children. Additionally there is a need to provide competent supervised visitation services across the county for families experiencing DV.

Two: Improve professional responses to children and families

- ***Recognize and understand the effects of DV on children.*** Provide more information and train professional providers to raise their awareness about DV and children.
- ***Screen children for the effects of DV.*** Professionals in all disciplines that work with children and families need to recognize the importance of screening for the effects of DV. Develop easily accessible and adaptable screening guidelines to assist providers.
- ***Thoroughly assess children.*** Thorough assessments are needed to determine the frequency, type, and effects of DV exposure, children's strengths and protective factors, child-parent relationships, and what supports or services the family has access to.
- ***Develop protocols, training and guidelines on effective responses.*** Train to build provider expertise so that they may respond in safe and appropriate ways, including learning to deliver supportive messages to children and parents and gauging their needs and readiness to take action. Make recommendations and guidelines available countywide so there will be consistent practices across agencies and disciplines.
- ***Increase communications, coordination and collaboration among service providers.*** Better coordinate services to increase accessibility. Consider providing a central access point to better engage families in services. Some providers do not know where to refer clients. Develop community resource guide and referral guidelines for existing services and resources.

Three: Develop community strategies

- ***Work on the attitudes, values and norms that perpetuate violence.*** Change our tolerance for violence. Have community conversations about DV in families. Work on the misconceptions that DV is not harmful to children. Communicate to all that DV is not acceptable for anyone. Involve males in mentoring and role modeling positive behavior.
- ***Provide community education campaigns.*** Stop publicizing only the severe DV cases on television and radio and in newspapers. Develop public awareness campaigns that include an array of messages, including some tailored to unique cultural and language needs of diverse populations. Address what happens to children and how DV affects their lives.

- ***Have community members learn how to safely take action.*** Many informants spoke about the need to move beyond just providing DV education to recommending that community members acquire new skills to help them safely support children and families.
- ***Focus on prevention efforts.*** This focus can be accomplished by increasing DV training in schools, and could be an effective strategy to stop the cycle of violence in the next generation.
- ***Call for community champions to join the efforts.*** Identify and engage recognized community leaders to become champions for children exposed to DV. Community champions could raise awareness about the issue and draw attention to the need for programs and activities.

Section One: Needs Assessment Project

Background, Purpose, and Methods

Background: Providers among agencies across King County of Washington State have long recognized that children living with or have been exposed to acts of domestic violence (DV) between their significant adults or caregivers can be profoundly affected in a multitude of ways. During the 1990's, efforts began with local government, public agencies and private providers to initiate dialogue, and to plan and develop strategies and programs. Although these community planning efforts had started, they were not sustained. Prior to this Safe and Bright Futures Project, there has not been a comprehensive assessment of the prevalence of the problem, the numbers of children served by existing services, and DV survivors and professionals providers concerns for children exposed to DV. These issues make it quite complex when communities are attempting to design a system of care for this population.

At the national level, specific legislative and program changes grew out of concern for the youngest victims of DV, children. President Bush created the *Safe and Bright Futures for Children's Initiative* in 2004 to support strategic planning for children exposed to DV in communities across the United States. This initiative was made available through the U.S. Office of Public Health and Science and Department of Health and Human Services. The purpose of the initiative was to develop community strategies targeted to diminishing the damaging effects of DV on children and youth and to stop the perpetuating cycle of abuse. In October 2004 King County was one of twenty two sites across the country to receive this award. Public Health – Seattle & King County in full partnership with King County Judicial Administration and their community partners implemented this project.

Project Purpose: The primary purpose of the community needs assessment was to gather available community data and in-depth qualitative data from providers and DV survivors. The findings formed the basis of a strategic plan for a comprehensive, countywide system of care. Although this tangible goal was important, another purpose was to create a community process where everyone would share their knowledge and experiences and come to agreement on priorities, prevention and intervention approaches, and community service models.

Methods: From December 2004 through March 2006, the project partners planned, developed and implemented an extensive community needs assessment process to identify and collect data. These were the methods.

- **One,** the project gathered existing community information, including a review of King County regional profiles, relevant 2000 Census data, estimates of the number of children exposed to DV, service data, and a review of local reports (See sections two & three of this report).

- **Two**, the project collected information on the needs of children exposed to DV from those who had experienced it, including adults who experienced DV as children, teens who were exposed to DV as children or youth, and mothers whose children were exposed to DV. This information was collected through individual interviews and focus groups (See section four of this report).
- **Three**, as available community data were limited, other methods were used to gather extensive input from community providers, including conducting community stakeholder meetings, project advisory group meetings, provider surveys, key informant interviews, and focus groups (See section five of this report).

Section Two: Community Profiles and Service Data

This section will present the data that was collected from available community data for the Safe and Bright Futures Project (SBF) needs assessment project. This includes information collected data from the following sources:

- King County regional reports
- Census data and other sources
- Homeless counts
- Law enforcement
- Child Protective Services
- King County Superior Court Protection Order Advocacy Program and Family Court Services
- Community-based DV agencies service
- King County crisis line calls

2.1 *King County and Regional Profiles*

The information in Section 2.1 summarizes the King County Demographic information as reported in the most recent King County Annual Growth Report². Located on Puget Sound in Washington State, and covering more than 2,130 square miles, King County is nearly twice as large as the average county in the United States. With more than 1.7 million people, King County is the most populated county in Washington State, with nearly 30 percent of the state population. It also ranks as the 13th most populous county in the nation. King County's population has grown by 18% since 1990.

In recent years, King County has seen a tremendous influx of immigrants and refugees. According to the 2000 Census, 27% of the King County residents are people of color (compared to 15% in Washington State), and 5.5% is Hispanic. Between 1990 and 2000 the Hispanic or Latino population has doubled and Asian population has increased by 70%. Countywide, foreign born populations have doubled.

² King County Budget Office (2004). The 2004 King County Annual Growth Report. Report available: www.metrokc.gov

Since 2001, King County continues to face an economic recession with the aftermath of September 11, 2001 and work reductions in aerospace and web based industries. Even though the area has been in a recession, housing prices have remained stable and the median value of housing has far outpaced inflation. The 2000 Census found that the median value of a single family home increased by 69%. The high housing prices within the large urban cities which has led to some demographic shifts among the suburban regions. The 2000 Census also reported a slight increase from 8.0% to 8.4% of the population living below the poverty level.

The City of Seattle is the largest among 39 separate cities located in King County. With large and diverse populations and needs, local governments and human service agencies often break King County into clusters or regions. These regions are the City of Seattle, North King County, East King County and South King County (Figure 1). Each region has a different composition of urban and rural cities, as well as urban and rural unincorporated areas. The City of Seattle is an urban city that continues to hold nearly one third of the county's population and has the highest numbers of non-white populations of all the regions. South County has had the biggest share of the county's growth and has the largest geographical and populated areas of the regions with more than 630,000 residents. South County has 13 urban cities, six unincorporated urban areas, three rural cities, three unincorporated rural areas, and the Muckleshoot Indian Reservation. East County has the second largest city, Bellevue. East County has a total of 12 urban cities, six unincorporated urban areas, five rural cities, and two unincorporated rural areas. North County is the smallest of the regions both in geographical area and population. North County has five urban cities and three unincorporated areas.

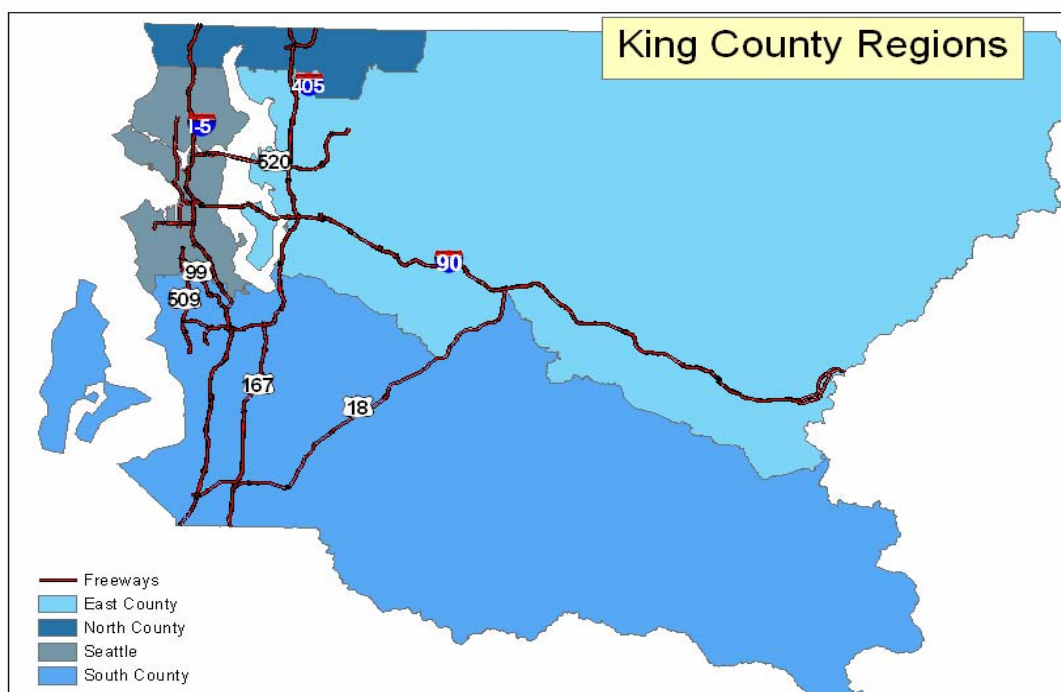


Figure 1: Map of King County and King County Regions

2.2 2000 Census Data for King County and its Regions

The U. S. decennial Census is the only population-based study source of information available to determine demographic characteristics of children. It is, however, important to note census data limitations. Data are gathered through self-report and reflect what respondents are willing to tell. They do not capture information on homelessness or multiple families living in a household. Non-documented people may not complete the census or complete it inaccurately because of fear of being reported to immigration services.

From the 1990 to the 2000 census, the number of children that lived in King County increased by approximately 14%. In 2000 there were 390,646 children under age 18 living in King County. Children are defined in the census as children under the age of 18 years, excluding those who maintain households, families or subfamilies as a reference person or spouse.

Figure 2 illustrates children's ages by county region to help understand where children live. In 2000:

- South County had 169,763 children (43% of King County children)
- East County had 100,216 (26%)
- City of Seattle had 87,800 (23%)
- North County had 32,867 (8%)
- The age distribution is roughly comparable across regions.

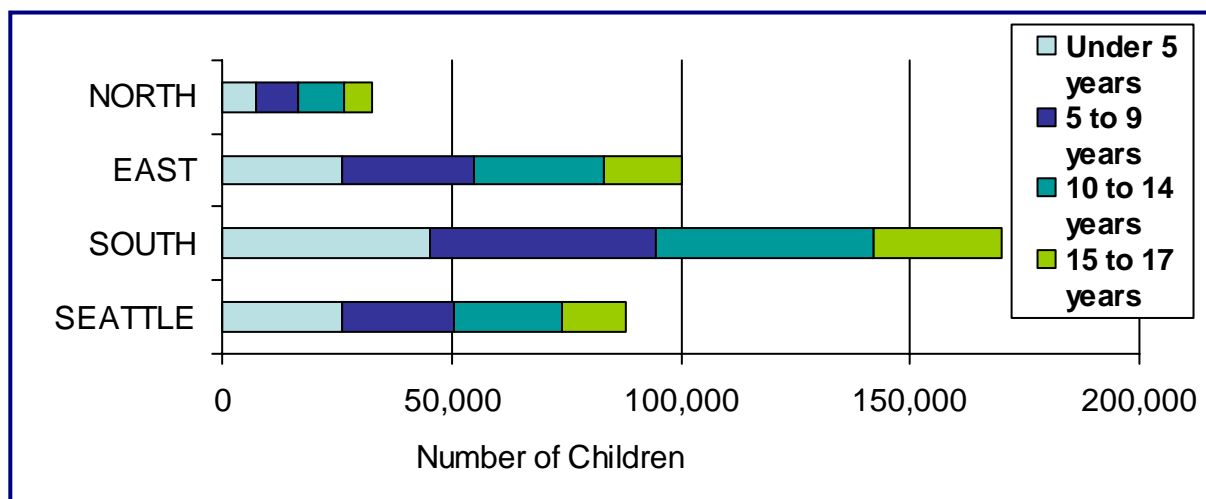


Figure 2: Numbers of Children living in King County Regions

In 2000 children's race/ethnicity in King County was reported as follows:

- 77% were White
- 13% Asian/Pacific Islander
- 9% Black
- 8% Hispanic/Latino ethnicity.
- 1% American Indian/Alaskan Native

The percent of White children compared to racial/ethnic children was highest in all four regions (see Figure 3). In the City of Seattle, however, the percent of children of color was almost half of the total population of children. South County had the next highest percent of children of color. "Other" included those who identified as "other race alone," and "two or more races."

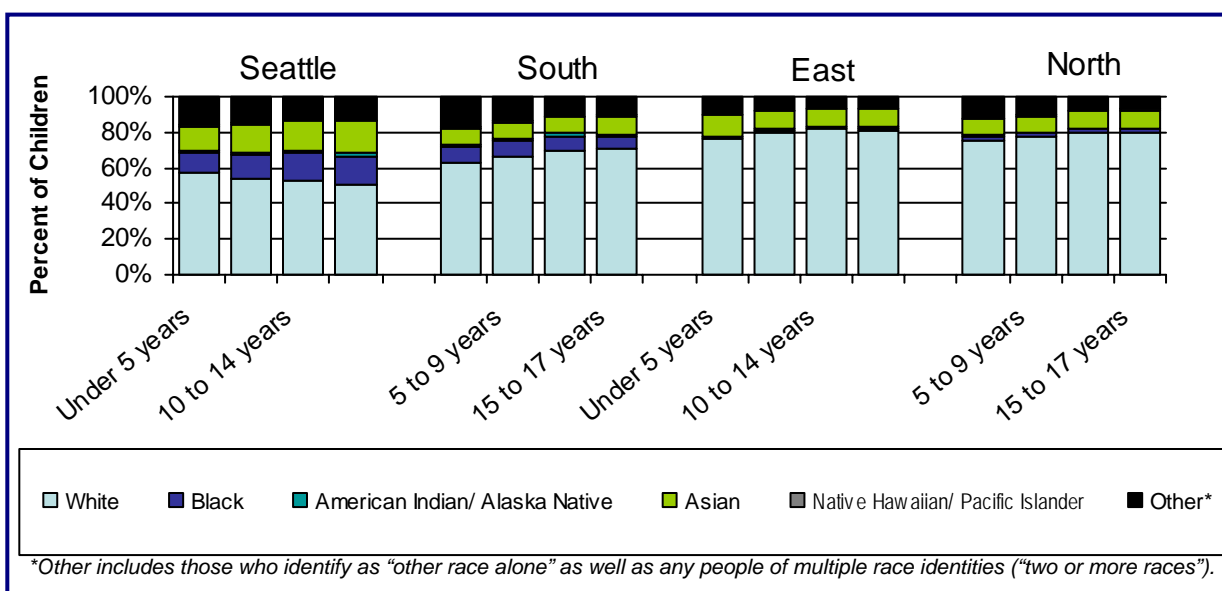


Figure 3: Children living in King County by Sub Region, age and race

The age distribution of Hispanic children status was similar in all regions. The largest percentage was Hispanic children under five years of age, approximately one-third of all children. The smallest percentage was made up of children 15-17 years of age (see Figure 4). Respondents had the option of choosing Hispanic/non-Hispanic in addition to a self-identified race.

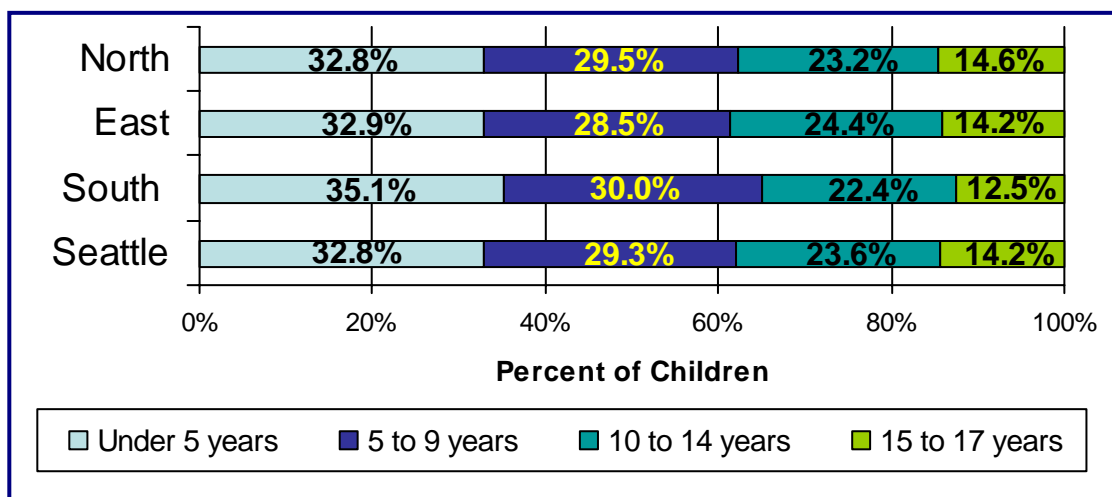


Figure 4: Hispanic/Latino children King County Sub Region and age

Although race data can be an indicator of minority populations, it does not fully describe the cultural differences among racial groups. Therefore census data was also reviewed for “foreign born” children, which is defined as children who were not U. S. citizens at their birth. Table 1 displays the top five countries of origin for foreign born children by region. Only children from Mexico were represented in all the top five lists. Those born in Vietnam, Korea, and the Philippines were in three out of the four regions.

	Seattle	Number & % of Total Foreign-Born			North	Number & % of Total Foreign-Born	
1	Philippines	12361	13.0%		Korea	1693	9.5%
2	Vietnam	11305	11.9%		Canada	1605	9.0%
3	Mexico	7902	8.3%		Vietnam	1561	8.8%
4	China**	7715	8.1%		Mexico	1448	8.1%
5	Canada	5302	5.6%		Philippines	1308	7.3%
	Other	44585	47.0%		Other	7615	42.7%
Total # Foreign		94932	100.0%			17831	100.0%
	South	Number & % of Total Foreign-Born			East	Number & % of Total Foreign-Born	
1	Mexico	14817	16.3%		Canada	6260	9.7%
2	Vietnam	9847	10.8%		Mexico	5118	7.9%
3	Philippines	8346	9.2%		China	4838	7.5%
4	Korea	6753	7.4%		India	4060	6.3%
5	Ukraine	5634	6.2%		Korea	3780	5.9%
	Other	45397	49.8%		Other	24056	37.3%
Total # Foreign		91083	100.0%			64439	100.0%

For those born in a foreign country, top five countries with highest number of foreign-born by region.

*This list only ranks single countries, so regions (such as Eastern Africa) that had a high number of foreign born were not ranked if one single country from that region did not have a high enough number of foreign-born. **China** does not include Hong Kong & Taiwan

Table 1: Top 5 Countries of Birth for Foreign-Born Children by Sub Region

Table Two displays countywide data for the five most frequently languages spoken at home other than English. Spanish is the most frequently spoken language followed by Vietnamese and Chinese.

5 to 17 years old				
	Seattle	South	East	North
1	Spanish*	Spanish*	Spanish*	Spanish*
2	Vietnamese	Vietnamese	Chinese	Chinese
3	Chinese	Other Slavic Langs	Korean	Korean
4	African Languages	Russian	Japanese	Vietnamese
5	Tagalog	Korean	Russian	Russian
Total Pop Ages 5 - 17	61234	124247	73897	25176
Total not English-only	14114	22196	11279	3470
% of Total not English-only	23.05%	17.86%	15.26%	13.78%
18 years and over				
	Seattle	South	East	North
1	Spanish*	Spanish*	Spanish*	Spanish*
2	Chinese	Vietnamese	Chinese	Chinese
3	Tagalog	Tagalog	Japanese	Korean
4	Vietnamese	Korean	Korean	Vietnamese
5	Japanese	Chinese	German	Tagalog
Total Pop Age 18 & Over	476242	464946	305669	101142
Total not English-only	94299	83608	55123	15531
% of total not English-only	19.80%	17.98%	18.03%	15.36%
NOTE - these data do not tell us who speaks only a language other than English at home. They just tell us what other languages are spoken at home				

Table 2: Top Five Languages spoken at home other than English

Census data were reviewed to assess “family” and “related children”. Family household is defined as a group of two or more people (one of whom is the householder) related by birth, marriage or adoption and residing together. Families are categorized as “married couple”, “female householder” (female maintained household with no husband present) or “male householder” (male maintained household with no wife present). “Related children” are defined as all people in a household under the age of 18, regardless of marital status, who are related to the householder. Figure 5 displays countywide data on number of children by marital status of household. Female-headed households outnumber male-headed households. Overall, South King County has the most families compared to other regions.

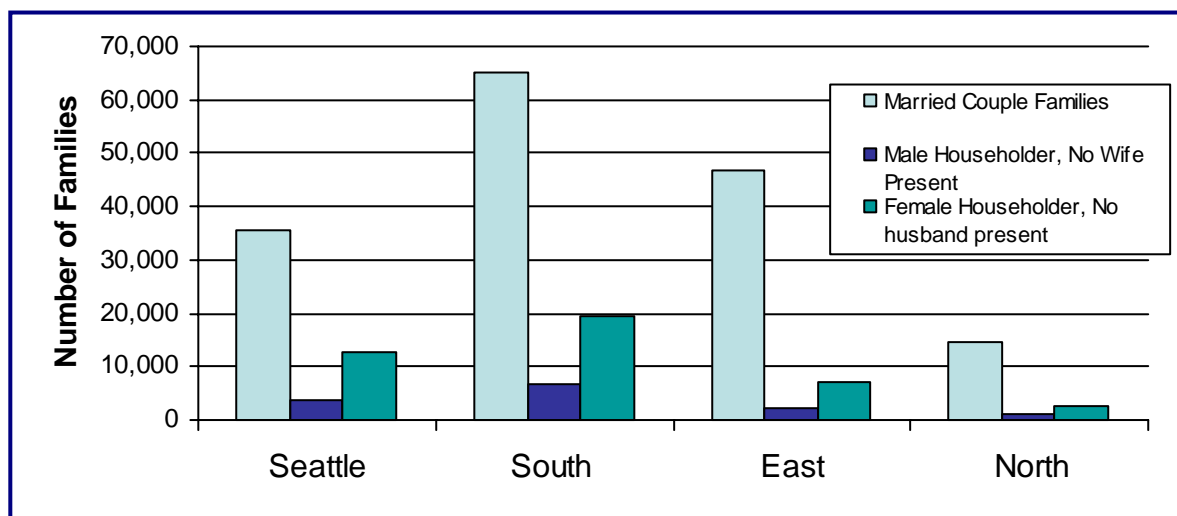


Figure 5: Types of families with related children

“Poverty level” is a set of money income thresholds that the Census Bureau uses to detect who is poor by family size and composition. The living wage income (200% of poverty level) used in the 2000 census was \$34,100 for a family of four. This living wage income is the threshold for Medicaid eligibility for children in Washington State. It is worth noting that eligibility for TANF is based on 44% of poverty, and the Basic Food Program is based on 130% of poverty.

Figure 6 displays data on the number of children below 200% of the poverty level by region and age. For all King County regions, children birth - 11 years were most likely to be living in a household earning below a living wage. In the South County and City of Seattle regions, approximately one quarter of all households earned below a living wage.

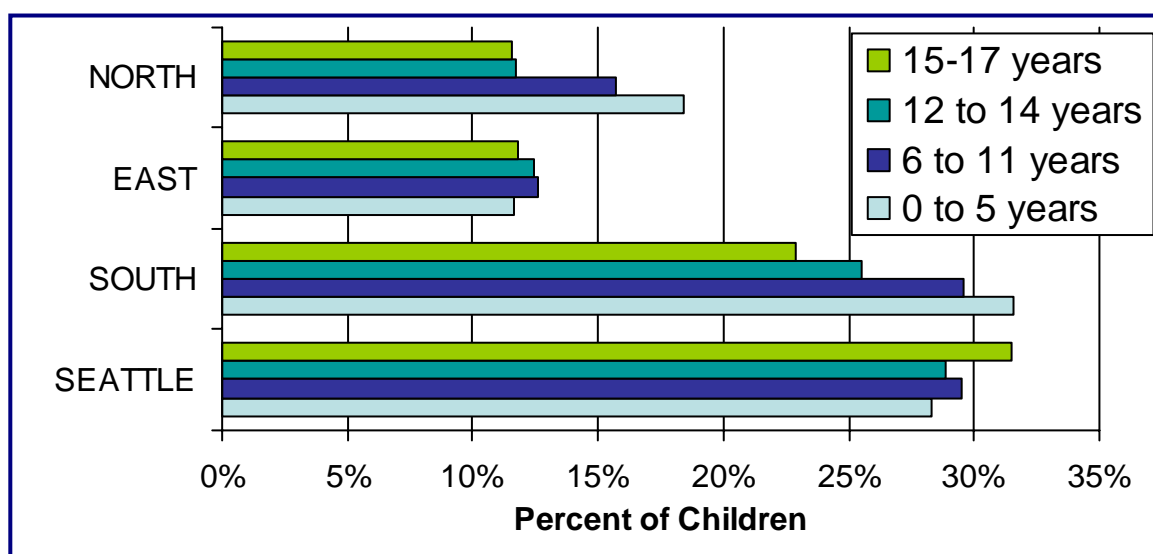


Figure 6: Percent of children under 200% of poverty level by sub region and age

Figure 7 displays data on families with related children who were living below 200% of the poverty level by family type. The analysis shows that for families in poverty, female-headed households outnumber married couple households in all regions. In South County and the City of Seattle, female headed households dramatically outnumber others. South County had the highest level of families living in poverty across family types, and the City of Seattle had the second highest number of families living in poverty.

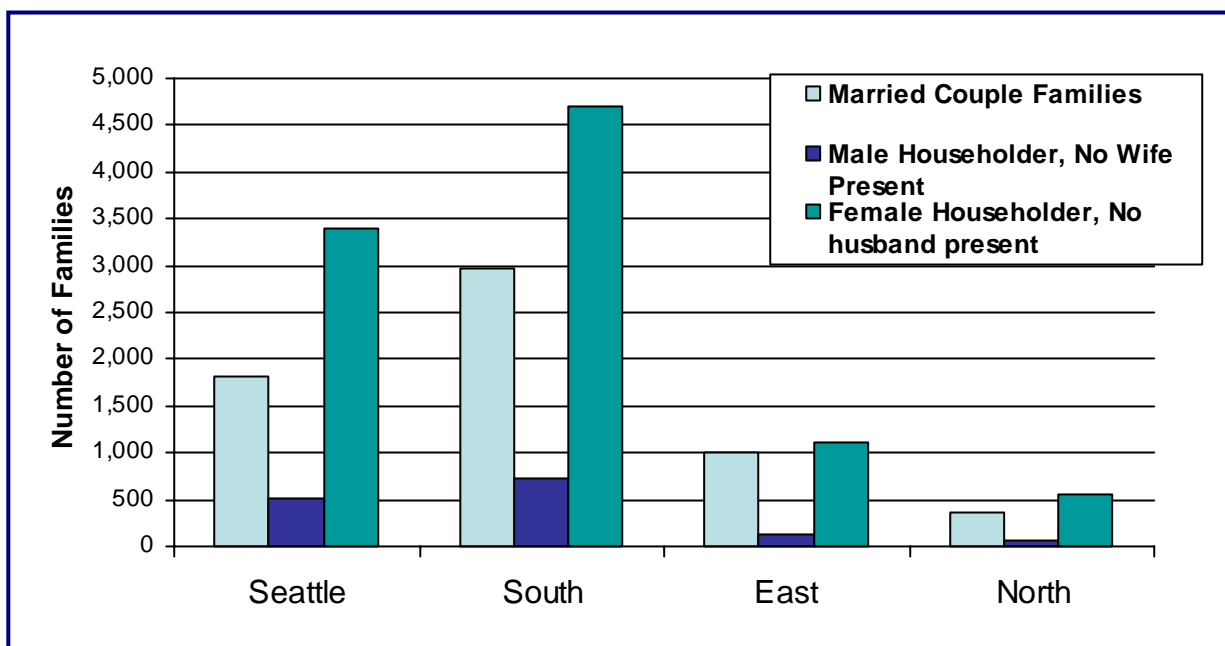


Figure 7: Families with related children living below 200% of poverty level

2.3 Estimates of King County Children Exposed to Domestic Violence

There is no mechanism in place for the systematic collection of information on the incidence or prevalence of King County children exposed to DV. King County, not unlike most areas across the United States, relies on population estimates derived from the research literature findings. Carlson, in her 2000 article on children exposed to Intimate Partner Violence (IPV), defines domestic violence as occurring between intimate partners, and conservatively estimates that 10% to 20% of children are exposed to IPV on a yearly basis³. Carlson further estimates that about 33% of children and youth are exposed to IPV sometime in their childhood or adolescent years.

If Carlson's study estimates are applied to the 2000 census data approximately 39,064 -78,129 children and youth may be exposed to DV each year. Similarly, an estimated 128,913 children and youth may be exposed to DV during their childhood or adolescent years.

³ Carlson, Bonnie (2000). Children exposed to intimate partner violence: Research findings and implications for intervention. *Trauma, Violence & Abuse*, 1(4), 321-342.

The only DV data that is collected in King County about infants, children and youth are service delivery data gathered when providers and system responders intervene with families. Information regarding providers' service delivery data is presented in the remainder of this section.

2.4 Homeless Data

Census data do not capture information about homelessness for families experiencing DV; therefore, other data sources were evaluated. The Seattle/King County Coalition for the Homeless does complete yearly "one night counts" of homeless families living in emergency or DV shelters⁴. In the annual one night count on October 22, 2004, the Coalition found:

- 4,636 unduplicated persons in homeless shelters across King County.
- Of those, 1,227 individuals were adult women with children.
- Homeless individuals listed DV as one of the top seven social concerns that they face when providers interviewed about major health concerns.⁵

On any given night, there are roughly 137 beds available for DV survivors and their children in either confidential or non-confidential locations. The demand for shelter beds for families experiencing DV far exceeds current capacity. In 2005:

- For DV shelter programs based in the City of Seattle the turn-away rates for DV shelter beds were roughly twelve to one.
- The turn-away rates in other King County DV shelter beds (Domestic Abuse Women's Network and Eastside Domestic Violence Program) were reported to be eighteen to one.
- In total, over 15,000 requests for DV shelter beds in King County were denied (note that this number is a duplicated count of families requesting shelter).⁶

⁴ Seattle/King County Coalition for the Homeless (March 2205). The 2004 Annual One Night Count: People surviving homelessness in King County, Washington. Report available through: [www@homelessinfo.org](http://www.homelessinfo.org)

⁵ Health Care for the Homeless Network (2204). 2004 Annual Report. Report available through www.metrokc.gov/health/hchn

⁶ Olsen, L. (April 2006). Issue brief: Domestic Violence and homelessness in King County. Brief is available through the City of Seattle, Human Services Department, Domestic Violence and Sexual Assault Prevention Division.

2.5 Law Enforcement Data

Most law enforcement agencies across King County routinely collect and report information about responses to DV calls. Table 3 lists the number of calls about DV to law enforcement agencies

Area Served	Number of Law Enforcement DV Calls
King County*	10,523
City of Seattle	12,026
Other King County Cities**	7,816
<i>* Includes areas across the county served by King County Sheriff's office or unincorporated areas and their contract cities.</i>	
<i>** Other cities includes data from Auburn, Bellevue, Black Diamond, Bothell, Des Moines, Enumclaw, Federal Way, Issaquah, Kirkland, Lake Forest Park, Pacific, Redmond, Renton, Snoqualmie & Tukwila.</i>	

Table 3: 2004 law enforcement response to DV calls

Not all calls for a DV response to law enforcement result in an arrest. In fact only about 19% of cases result in an arrest. Table 4 displays the number of cases and area served where an arrest was made in 2004.

Area Served	Number of DV arrests by Law Enforcement
King County*	1,585
City of Seattle	2,025
Other King County Cities**	3,143
<i>* Includes areas across the county served by King County Sheriff's office or unincorporated areas and their contract cities.</i>	
<i>** Other cities includes data from Auburn, Bellevue, Black Diamond, Bothell, Des Moines, Enumclaw, Federal Way, Issaquah, Kirkland, Lake Forest Park, Pacific, Redmond, Renton, Snoqualmie, Tukwila and Kent.</i>	

Table 4: 2004 law enforcement DV arrests in King County

Law Enforcement agencies do not routinely collect information about children present at a reported DV incident. However, the King County Women's Program, DV/Child Protective Services (CPS) Best Practices Workgroup completed a two-year follow up on documentation effectiveness for the KCSO officer training project in October 2004. The evaluator reviewed 93 KCSO officer reports, from January 1 - March 31, 2005. Each report documented an officer response to a DV scene where children were present. The evaluation found that:

- In the 93 cases, 138 children were present at the DV scene.⁷
- In 20% cases (19), weapons were reported in the home or in possession of the perpetrator.
- In 19% of cases (18), there were documented safety risks to children. Felony charges were filed in eight of those cases (44%) with charges for felony harassment, felony threats, and Assault 2- with a deadly weapon (see Appendix A for information from the evaluation).

2.6 Child Protective Services Data

In King County, the Division of Children and Family Services (DCFS) have Child Protective Services (CPS) units that respond to referrals of child abuse and/or neglect (CAN). CPS routinely collects data on the number of referrals that are accepted for CPS investigation. In 2004 there were 5,215 referrals (7,845 children) that were accepted for CPS investigation (see Appendix B for a summary of 2004 King County CPS data).

CPS does not routinely collect data pertaining to the number of children referred to their agency that have indications of DV. However, a recent statewide CPS study conducted by English, Edleson & Herrick can be applied to arrive at population based estimates for King County children who have co-occurring CAN concerns and DV exposures. Using a random sample of 2,000 Washington State CPS referrals, English, Edleson & Herrick estimated that 47% of the referrals accepted for CPS investigation (those referrals with moderate, moderately high, or high risk of CAN) have some indication that adult DV was also occurring in the referred child's home.⁸

- If the estimates from the aforementioned study were applied to the 2004 King County CPS data, 47% of referrals accepted for CPS investigation, or 2,415 referrals involving approximately 3,687 children had indications of DV at the time of referral to CPS (see Figure 8).

English, Edleson & Herrick also evaluated the case outcomes for the CPS referrals with DV indications for up to one year after the CPS investigation had occurred. They found in Washington State as a whole, CPS investigated cases with DV indications had the following outcomes:

- 68.1% would be re-categorized as low risk or moderately low risk after investigation

⁷ Greenleaf, Deborah (November 2005). Summary report of the evaluation of KCSO training project is available through King County Department of Community and Health Services, Community Services Division, King County Women's Program.

⁸ English, D., Edleson, J. & Herrick, M. (2005). Domestic violence in one state's child protective caseload: A study of differential case dispositions and outcomes. *Children and Youth Services Review* 27(2005), 1183- 1201.

- 31.9% would remain at moderate or high risk after CPS investigation, and of these cases, 62.5% would be opened for CPS services

Of the DV cases receiving CPS services:

- 55.7% would be re-referred to CPS intake within one year, and/or
- 80.7% would have children placed out of the home within a year

If the estimates from the aforementioned study were applied to the 2004 King County CPS data for the 2,415 investigated cases with DV indications, the following outcomes would be (see Figure 8):

- 1,669 (68.1%) cases would have been re-categorized as low risk or moderately low risk for CAN after investigation
- 746 (31.9%) families would remain at moderate to high risk for CAN after investigation, and
- 465 (62.5%) families would be opened for CPS services

Of the 465 cases remaining open for CPS services:

- 259 (55.7%) would be re-referred to CPS for a new allegation within one year, and/or
- 375 cases (80.7%) would have children placed in out of home care within one year

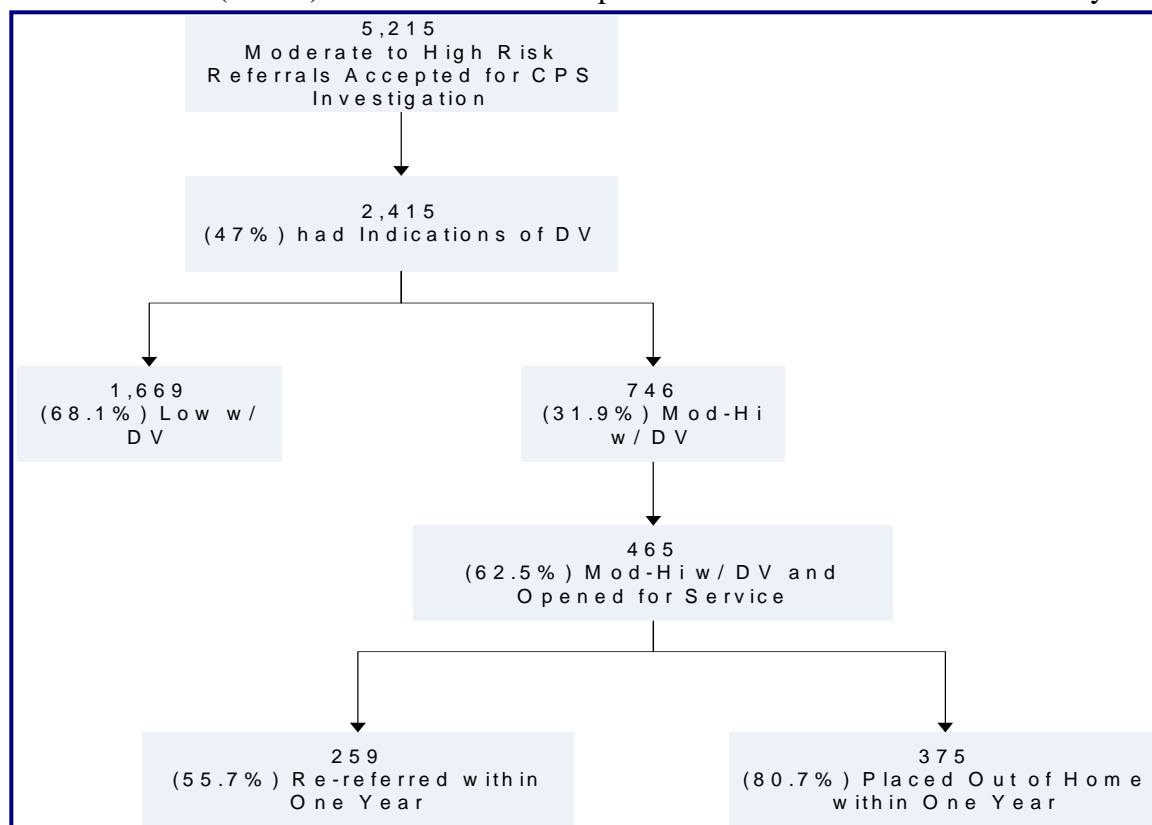


Figure 8: Population estimates for children receiving CPS investigation and who have adult DV exposures

2.7 King County Superior Court, Prosecuting Attorney's Office, Protection Order Advocacy Program Data

A Protection Order is a civil order described by Washington State Law, RCW 26.50. This order is designed for people who are experiencing physical violence, threats of physical violence (those who fear imminent harm), sexual assault or stalking committed by a family or household member. Although a civil order, a violation of the restraint provisions of the order may result in the filing of criminal charges. The order can restrain the abusive family member from committing acts of harm, contacting the victim and/or minor children, and from coming to the home, school, workplace, daycare, or other designated location. A temporary protection order can be obtained at any District or Superior Court, and most Municipal Court locations in King County.

The King County Prosecuting Attorney's Office, Protection Order Advocacy Program, provides advocacy services and assists people who wish to file protection orders against an abusive partner. The program has found that most of the families are not engaged with community DV advocacy services for the DV survivor or children at the time they are seeking protection orders. Protection Order Advocates are available to help with the filing of orders in three locations: Seattle King County Superior Court, Kent Regional Justice Center and Redmond, East Division, King County District Court

The Protection Order Advocacy Program collects demographic and case specific data on cases heard before the King County Superior Court locations in Seattle and Kent. Typical case distinctions for all Protection Order cases set for full hearings include: case adjudication, relationship between the parties, and number of children protected by the order. Data on Protection Orders initiated through District and Municipal Courts are not collected by the Protection Order Advocacy Program, and therefore, are not included in the following 2004 data summary.

- 4,754 families requested permanent (or full) protection orders through King County Superior Courts, Seattle and Kent.
- Of those, 2,682 (56%) families were served by the Protection Order Advocacy Program at their full order hearing.
- In 1,691 (63%) of families served by the Protection Order Advocacy Program the petitioners included children on the orders. This resulted in 2,879 children protected by orders.
- 725 (27%) of the orders did not include children, and in 266 (10%) of the orders there was no or insufficient data recorded about children.

2.8 Family Court Services, King County Superior Court

Family Court Services (FCS), a program of King County Superior Court, prepares forensic assessments in family law cases. These assessments include DV Assessments and Parenting Plan Evaluations. The types of cases that reach FCS are generally dissolutions, modifications of existing parenting plans, and petition for protection orders. FCS is operated out of the two Superior Court locations: Seattle King County Courthouse and Kent Regional Justice Center. FCS provides crucial information to judges and court commissioners in order to assist them in making decisions about the best interest of the children as it pertains to the residential schedule, needed services, and potential safety issues.

A FCS *DV Assessment* process consists of obtaining information from individual interviews with the parents, review of pertinent legal files, review of police incident reports, and review of information gathered through collateral contacts and other relevant information sources. The FCS social worker produces a report that summarizes their investigation. The report includes identified concerns and appropriate recommendations. DV assessments are distributed to the court and the parties. Reports are distributed on the day of the hearing to maintain safety of DV survivors.

In 2004, 206 DV assessments were completed by FCS involving 289 children/youth. The ages of children were:

- 135 (47%) ages birth-five years
- 106 (36%) ages 6-11 years
- 48 (17%) ages 12-18 years

In cases where parenting of minor children is at issue, FCS will be asked to conduct an investigation and make recommendations in the form of a *Parenting Plan Evaluation*. Cases come to FCS when parents cannot agree on a final parenting plan and are in the process of taking their case to trial. A Parenting Plan Evaluation provides the court with a picture of the family and provides recommendations as to a residential schedule that best meets the needs of the children. FCS also prepares Parenting Plan Evaluations where the court has identified issues with one or both parents due to mental health, substance abuse, or DV, and the court requires additional information to assess the potential risks to the children. Parenting Plan Evaluations require a minimum of 90 days for the evaluator to complete. The Parenting Plan Evaluation and report includes information gathered through individual parent interviews, review of pertinent legal files, police incident reports, school records, collateral contacts, and other relevant information sources. Additional information may be gathered by observing the parent with the children in an office or home visit. The FCS Parenting Plan Evaluation is provided to the court and all parties at least ten days prior to the scheduled trial date. FCS will also provide to the court information on potential service providers and other referral information in cases where services are being recommended for the family.

In 2004, 392 Parenting Plan Evaluations were completed by FCS involving 572 children/youth. The ages of children were:

- 187 (33%) were ages birth-five years
- 239 (42%) were ages 6-11 years
- 146 (25%) were ages 12-18 years

In 192 (49%) of the families assessed for Parenting Plan Evaluations, there were indications of DV. Of these cases:

- 112 (58%) had indications of parental substance abuse
- 50 (26%) had indications of child maltreatment.

2.9 Community Based DV Agencies Services Data

Community-based DV providers deliver services and track non-identifying information about the services and needs of children exposed to DV. Although there is strong interest in targeted services for children, funding for children's services has been lacking. This lack of funding has hampering the development of service delivery and data collection. Presently, little is routinely collected about the needs of children. The only information that is collected pertains to the number of children served, their ages, sex and race. Little or no information is collected on children's special needs or disabilities.

In order to collect information about children served in the county, the Safe and Bright Futures Project in 2004 surveyed seven community-based DV programs including emergency shelters, transitional housing and community-based advocacy programs. The survey revealed that 76% of households seeking services had children. The remainder of this section summarizes the information gathered through the survey regarding 2004 service data.

Emergency Shelters Services for DV Survivors: Five out of six emergency shelters responded to the survey. The services provided by emergency shelters included childcare, parenting education/support for mothers, one-to-one support, support groups, and outings for children. A short-term therapy research project has recently been added at the three confidential DV shelters. In 2004:

- 572 households with 612 children were served by emergency shelters
- Among the households, 90% had no or low incomes
- Over 25% came directly from another county or relocated from out of state, reflecting the instability and crisis these families encounter

- Among the children served by the shelter programs:
 - 72% were children of color
 - 32% were African American
 - 13% were Latino
 - 53% of children were infants, toddlers and preschoolers
 - 78% were ten years of age and younger

DV Transitional Housing Services: Six of seven domestic violence transitional housing programs completed the survey. Transitional housing program residents most frequently are referred to transitional housing from DV emergency shelters. Transitional housing services for children are more extensive than those in emergency shelters, but include the same advocacy-based services, child care, parenting education/support for mothers, one-to-one support, support groups, and outings for children. In 2004,

- 122 households were served by transitional housing services
- 213 infants, children and youth were served
- Households had similar income levels and ages of children to those seeking emergency shelter. Among households
 - 31% were refugee/immigrant household
 - 27% were Latino families.

In summary, there were more children, greater percent of Latino families served by transitional housing services than by emergency shelter services.

Community Based DV Agencies: All seven community based DV agencies completed the Safe and Bright Futures survey. In 2004 these agencies provided services to over 2,400 households. They reported that services specifically aimed to the children are scattered. While some agencies have developed unique approaches to working with children, such as support groups and in-home follow-up, not all agencies work with children. In addition, most agencies do not offer services to children independent of their mothers' participation in the program.

2.10 Calls to King County Crisis Clinic Line for Children Exposed to DV

The King County Crisis Clinic operates a 24-hour crisis line for people in immediate emotional crisis. Trained phone workers talk with callers about their concerns, help them sort through their feelings, and refer callers to agencies for additional help. The Crisis Clinic also operates a community information line that provides assistance to people seeking resources. Information and referral specialists also provide advocacy and follow-up for callers who have difficulty accessing services on their own.

Approximately 155,000 telephone calls are made to the crisis line and community information line each year. Calls are predominately for King County resources and assistance. The Crisis Clinic does not have data specific to the number of calls made by families experiencing DV; however, the Crisis Clinic does record the types of referrals made for children and their families.

The following is a summary of referrals made by Crisis Clinic operators during 2004 (the data provided is limited as it is difficult to separate out specific referrals made by the Crisis Line for children exposed to DV).

- 3,356 referrals were made to agencies that specialize in DV support and advocacy services. Of these:
- 1,105 were referred to Domestic Abuse Women's Network
- 524 were referred to New Beginnings
- 590 were referred to Catherine Booth
- 415 were referred to Eastside Domestic Violence Program
- 858 were referred to Child Protective Services
- 178 were referred to Childhaven Services (including referrals for daycare and emergency crisis respite services)

Section Two has summarized the available data for children and DV survivors. This section has included what was reported from census data, agency services and program data, and research findings and estimates.

Section Three: Community Reports

Two recent King County studies and one survey produced significant findings that are relevant to the Safe and Bright Futures needs assessment. The findings of three of those reports are presented because they examined the concerns and needs of:

- Children exposed to DV in ethnic and hard to reach populations
- Children and families involved in Family Court
- King County mental health providers who work with children and families exposed to DV

3.1 Cultural Issues Affecting Domestic Violence Service Utilization in Ethnic and Hard to Reach Populations Study⁹

This study was conducted by Public Health – Seattle & King County to examine DV service utilization and satisfaction among women from African American, Ethiopian, Cambodian, Filipina, Latina, Native American, Russian, and Vietnamese and Lesbian, Bisexual, and Transgender (LGBT) communities in King County. The study included 254 participants in 38 focus groups and 16 individual interviews. Women were questioned about their experiences in accessing services for their children and what was needed to improve community services (see Appendix C).

Key Findings

Women were asked what concerns they had for their children and youth exposed to DV. The most commonly reported concern across ethnic groups was that women were worried about the impact of DV exposure on their children.

- Amharic women reported children were often the only ones who really knew what was happening in the home, especially when families were isolated.
- African American women reported great concern with the distress and pain that witnessing abuse caused children.
- Across groups, women reported that DV exposure often caused children and youth to view abuse as normal, and that it was acceptable to hit or be violent. They expressed fear that their children would experience DV in their adult relationships.
- African American, Amharic, Filipina, and Native American mothers reported that children needed support and education to recognize DV, know what to do when it happens in their families, and children needed to learn about healthy relationships.

⁹ Senturia, K., Sullivan, M., & Ciske, S. (November 2000). Cultural Issues Affecting Domestic Violence Service Utilization in Ethnic and Hard to Reach Populations. Report available through www.metrokc.gov/health. The study was funded by NIJ.

Mothers were asked about what services they perceived as being helpful or not helpful for their children. Their suggestions were:

- African American, Cambodian, and Native American women reported a need for affordable and culturally specific counseling.
- African American, Latina, Native American, and Russian women reported a need for more child care assistance. Some suggested that there should be more attention paid to the needs of children/youth in shelter programs.
- Latina, Russian, Vietnamese, Native American, and Russian women reported a need to have healthy activities available for their children/youth, such as field trips, camp, and recreational activities, so that they might focus on their own lives rather than their mother's problems.
- Filipina, Native American, and Vietnamese women identified a need for children's support and peer groups.
- Ethiopian and Native American women spoke about the need for safe and healthy environments in which to raise children without the presence of gangs and drugs.
- Cambodian and Latina participants reported that mothers need guidance on how to best support and help their children.
- Others talked about concerns with Child Protective Services (CPS). African American, Filipina, and Native American women expressed strong concerns that CPS involvement causes more problems for their families because they could lose custody of their children.

Key recommendations

- ***Provide outreach*** to develop support networks for families that include cultural and language diversity and engage isolated families.
- ***Expand childcare support*** with skilled providers specially trained to work with children exposed to DV.
- ***Increase basic needs***, such as shelter services, transitional and long term housing, and transportation to services.
- ***Provide information*** to families on resources that are available at no cost to them.
- ***Provide community-wide education campaigns*** that have culturally specific definitions of DV, address shame and isolation among survivors, clarify the right to live without violence, negate social norms that support violence in families, provide information on how to help and support families living with DV, and provide information on culturally appropriate models of healthy relationships.

3.2 “I Just Wanted to Be Safe: Battered Women’s Experiences with the Family Law System in King County”¹⁰

The King County Coalition against Domestic Violence (KCCADV) conducted a study of DV survivors involved with the family law system. The purpose of the study was to assess the responsiveness of the system and obtain information on the problems DV survivors experienced in the family law system. Four focus groups were conducted with 48 survivors and five focus groups with 47 community providers in order to gather qualitative information on their experiences with family law proceedings.

Key Findings

Survivors were asked what outcomes they wanted for their children and families. Most reported wanting increased safety and security for their children and families by:

- Establishing primary custody or sole decision making with the survivor
- Restricted or supervised visitation with the abusive parent
- Establishing provisions for safe exchanges of children
- Enforcement of court orders
- Enforcement of child support

Survivors were asked what the outcomes of their family law cases were.

- There were problems with enforcement or modification issues particularly around child support and supervised visitation.
- Most did not get the protections or provisions that they wanted, such as primary custody and restricted visitation.
- Some got mandated joint decision-making when they did not want it, and mediation services which should have been waived in DV cases.

Survivors and providers identified a need for increased capacity in these areas.

- Legal representation in the dissolution process as many did not have legal representation, often leading to poor outcomes.
- Training for providers leading to greater awareness and understanding of what is needed by survivors and their children.
- Language and cultural services in the legal system for women of color, refugees, and immigrant women.
- Children’s services, including more low cost supervised visitation centers.
- Culturally specific community-based DV advocates for limited English-speaking survivors.

¹⁰ King County Coalition Against DV (December 2005). I just wanted to be safe: Battered women’s experience with the family law system in King County. Report prepared by Merrill Cousin. Report available: www.kccadv.org

The findings from this study were consistent with a separate study by Kernic, Monary-Ernsdorff, Koepsell, and Holt on child custody determinations in King County. The researchers also found that DV survivors were no more likely than the comparison group to be awarded primary custody of their children, and abusive fathers were no more likely than the comparison group to have limited custody or visitation.¹¹

3.3 Mental Health Providers Survey on DV training:

In November 2004, 63 mental health providers in King County completed surveys on their level of training and expertise in working with children and families experiencing DV¹². The survey addressed provider comfort in treating children, prior DV coursework and training, strategies to increase provider competency and the availability of DV consultation resources. The respondents were recruited through a convenience sample, and therefore, the results may not be representative of the greater mental health provider community.

Key Findings

Fifty-seven respondents stated that they had received graduate training. Among them:

- 72% reported no DV-specific coursework
- 12% reported one course on DV
- 16% reported comments, such as “not much,” “women’s studies,” or “one quarter on abuse including DV”

Fifth-nine respondents responded to the question about DV training “required by their respective agencies.” Among them:

- 63% reported no required DV training from their agency
- 24% reported one or more DV workshops during their employment with their agency

Of 63 respondents, approximately 50% stated that they had voluntarily completed DV training through independent study, conferences, or other agency sources.

Among 58 respondents to a question on how comfortable they felt treating children who had experienced DV:

- 64% of respondents reported feeling either very comfortable or comfortable
- 26% reported feeling mildly comfortable
- 10% reported feeling mildly to very uncomfortable

¹¹ Kernic, M, Monary-Ernsdorff, D., Koepsell, J., & Holt, V. (2005, August). Children in the crossfire: Child custody determinations among couples with a history of intimate partner violence. *Violence Against Women* 11(8): 991-1021.

¹² Self, J. (2004). Domestic violence training and consultation survey for mental health professionals. Summary report available through the King County Coalition Against Domestic Violence and South King County Community Network.

Of 63 respondents to a question on what would help them feel more comfortable treating children, they reported a need for:

- DV specific training for clinicians on conducting thorough DV assessments and safety planning.
- Effective culturally competent interventions for children of all ages
- Case consultation services
- Training on helping parents recognize DV effects on children
- Training on helping parents support the needs of their children

Other needed training topics identified by survey respondents (*listed from the most to the least frequently reported*):

- Promising practices for treating children
- DV in Cultural groups
- Mental health and DV
- Perpetrators as parents
- Impact of DV exposures on children
- Legal issues
- Safety planning
- Working with CPS in DV cases
- Immigration and policy issues
- Local resources
- DV in same sex relationships
- Power and control
- Treatment for batterers
- Forms of abuse
- Interventions for teens exposed to DV
- Interventions for DV survivors

Section Four: Interviews and Focus Groups with DV Survivors

4.1 Interviews and Focus Groups Methods

Purpose: Project partners wanted to gain a better understanding of children's and parents experiences, including:

- Where children and their families turned to ask for help.
- What their experiences were when they tried to access help.
- What they thought would be helpful for children.
- What ideas they had about preventing DV from happening in families.

Participants: Focus groups and individual interview were conducted with:

- Adults who were exposed to DV as children
- Teens who were exposed to DV as children/youth
- Parents whose children were exposed to DV.

Recruitment: Informants were referred to the assessment project in various ways.

- **One**, adults who had been exposed to DV as children were referred by project partners, or recruited at a November 2005 DV conference through a voluntary survey. As many participants had not disclosed their DV histories publicly, the assessment team made provisions to maintain confidentiality. Participants were interviewed individually in person or by phone.
- **Two**, teens who were exposed to DV were recruited through their DV support group meetings and participated in a focus group or individual interviews.
- **Three**, parents whose children were exposed to DV were recruited by the project partners, or through their DV support group, or through a November 2005 DV conference voluntary survey. Parents participated in a focus groups or individual interviews.

Sample description: Forty-two informants participated in focus groups or interviews. Of these participants:

- Fifteen were female and male adults or teens who were exposed to DV during their childhood or adolescent years.
- Twenty-seven informants were mothers whose children had been exposed to DV.
- Over one third of informants voluntarily identified their ethnicity/race as non-white, African American, Hispanic, or Native American.
- They voluntarily described having a range of moderately high to low financial resources and supports.

Sample limitations: All informants were self-selected through a convenience sample method. Their experiences may not be representative of others with similar experiences and the findings cannot be generalized outside the study sample. There may also have been issues of recall bias as many adults disclosed events that occurred many years ago. Some informants

reported that they had few or no opportunities to talk about their memories and that they had not thought about them for a long time. Others reported that many memories had been lost and they were not able to recall some details or events.

Method: Interview instruments and consent forms were developed in collaboration with the Safe and Bright Futures community partners, assessment team, and evaluation consultant, who has an extensive background in conducting qualitative research (see Appendix D). A process was followed to brainstorm and discuss topic areas, develop and review questions, and prepare the interview/focus group tool. The focus groups and individual interviews were conducted from November 2005 through March 2006 with sessions ranging from 1-2 hours. Notes were taken during the sessions, recorded electronically and kept on a secured database. To maintain confidentiality no names or personal identifying information were recorded. The entire Safe and Bright Futures Project team, design team and advisory group reviewed the findings.

4.2 Key findings from discussions with Adults and Teens who were exposed to DV as children or youth:

Teens and adults were asked about their childhood/youth experiences with DV including:

- ***Who in their lives knew that they were living with DV***
- ***What others did when they knew about it***
- ***If they talked with anyone in or outside their family about the DV***

One third of informants reported that they couldn't talk about the DV because they were too young, didn't have the words, didn't want to talk, or thought it was a normal experience.

"My teachers didn't know about it because we were quiet about it. My life was bad. I would block it out and try to be happy in school. I didn't want people to know."

"I thought my life was ok. I didn't want to look at the bad so I didn't talk about it."

"For a very long time I was told it was normal, so I didn't think I should be getting help for it. I couldn't identify it as an issue until my 20's."

Just over half of the informants reported that extended family members, neighbors, friends, minister, or counselor were aware of the DV and they reported positive and helpful experiences from the people who knew about the DV.

"Several older women in our community knew what was going on and spent time in our home as a protective function. They were friends of the family. They knew mother wouldn't leave my dad and they made many visits to our home because no violence occurred when they were there."

"They (grandmother and aunt) tried hard to be supportive of me. They were helpful in saying 'it was not your fault', or 'you can't change it', or 'you can't make it better'. That was great. It was the only help I got. I felt relaxed with them and loved by them."

Most informants talked about being isolated from other family members and not speaking with anyone, including parents, until they were older. Some did talk about the DV with their siblings but did not always find it to be a comforting experience.

"I started to talk about it when I was a teenager and I got big enough to fight my dad. When I lost my fear of my father I could talk about it."

"As kids we talked a lot about how I felt about it. I was so sad that my mom was being hurt. My sister was much more angry. She told me it (the violence and abuse) was my mom's fault and that my dad was a nice person until she yelled at him." "I did talk with my siblings, but we mistrusted each other as we were in competition with one another. We couldn't comfort each other."

Informants' experiences in seeking help/support for the DV:

When asked about seeking help or support for the DV as a child, only one informant reported a positive experience. She said that she would leave the home with her siblings when DV happened to seek safe locations in the community.

Most did not seek help or support because they thought they couldn't talk about it outside the family or shouldn't ask for help. Two informants wanted to get support but found no one could help them.

"When my parents had crazy fights we would flee on foot with my mom and he would follow us in the car. I would think where are the grown ups? Wasn't anyone out there that could stop and help us? I really needed and adult to talk to because they would find ways to get me help."

"I know now that my problems with school were linked with things going on at home." "I was severely bullied as a kid...They took me out of the advanced classes at school to protect me from being bullied. They put me into a remedial class, as I couldn't go anywhere else. I stopped doing my homework and I started having grade problems. I never got help with what was going on, I just got in trouble for it. No one offered me any counseling."

Two informants talked about trying to get help and going to neighbors who dismissed them, looked the other way, or refused to help.

"My older sister was smoking and hiding it. My dad forced her to eat the ashes from her cigarettes. My mom tried to intervene and she was physically attacked. I had witnessed this and ran to get a neighbor's house to get help. I was told by the neighbor that they wouldn't help me because it was my family's business and they had nothing to do with it. I was surprised at their response. I thought everyone knew what was going on with my family. I thought that this time it was so bad that I thought they should come and help me."

"After my brother's father trashed our house, slashed all of my clothes and my mother's clothes and set fire to the car outside, I went to my neighbors for help. Because I thought he would kill my mother. They wouldn't help me and told me to leave."

Others talked about the problems they had getting help from extended family members or the police when they knew about the DV.

"All of his family knew about the DV. We did try and talk to his family about the DV but they would manipulate the truth. They acted like it was ok."

"With our family we've been told to quit calling for help. My mom called the police many times and they never came. They are not out there helping us. If you have DV you have to make hard decisions. And they wonder why people don't report or press charges? It is because they are afraid what that person will do to them."

"The police weren't equipped to do anything. I wished they would have put him in jail because I was scared of him and I was afraid that he would hurt us."

Two informants talked about the difficulties and uncomfortable feelings in asking for help and reported that others were too scared or immobilized to help them or over-responded by giving too much help.

"It was hard to get help. When people knew about the DV they would take it against you, or they were too scared to help you."

"I put a letter in the need help box at my local school...I think I was overwhelmed by the amount of people trying to help me...and remember distinctly feeling like I had done something wrong or told a secret I shouldn't have. I was very concerned about getting my mom in trouble...wow, even 25 years later this is still with me."

Informant's suggestions for helping children:

Children need a way to talk about DV.

This theme resonated with the majority of survivors who reported that they felt alone and a sense of shame when they could not talk about what was happening to them.

"I needed other kids to talk to. I felt we were the only family in the world that was going through this. I almost feel like it made me feel dirty."

Encourage them to talk with other children and adults.

Survivors need someone they can talk with that can give them support, help them understand and validate the experience, and clarify misunderstandings.

"Children need a chance to talk to better understand what DV is and build their self esteem and problem solving skills."

"Children need affirmations from another adult about their situation. (Such as) I see what is happening and that it is not right. So that children don't think that they are crazy."

"Children are trying to figure out why things happen. If people aren't there to support them, they are going to find the answers themselves and misinterpret their parent's behaviors. Like my sister. Even now (many years later) she still blames my mom for the abuse."

Reach children/youth in schools.

"I would start in the schools. As a child that is where I went everyday away from my parents. There was so many times I almost slipped and told a teacher what had happened. If we trained our educators and school counselors to support kids with DV we could move mountains. So much could happen."

"Talking to kids in school normalizes the experience and sends a clear message that DV is not ok and that it is healthy to talk about it."

"In sex education classes where we are already talking about relationships, we should incorporate DV into the curriculum."

Encourage talking to a confidential counselor, telephone resource line person, DV camp counselor, or appropriate others in the community.

"We need something like Planned Parenthood. Something that you can go to that is confidential and parents don't know about it. You can go to someone who is confidential and you would be able to say what is going on. You need someone with a fresh and clear understanding to help find the possibilities for you."

"Start a resource line where children can call with DV issues"

"I love the idea of sending kids to DV camps. You have a safe place to sleep, to be with other kids to talk, and have a safe place to be a kid that's away from parents."

Make counseling and supports more available.

"It could be helpful to address the sense of fear and lack of control that it brings out in children which can later manifest themselves as anxiety disorders and unsuccessful relationships."

Help children develop safety plans so they know what to do when DV happens.

"Give attention to that individual child. Kids need help to develop their safety plan. When kids do a safety plan it makes them feel proud and competent. It is important to do this in the home as it is hard to get them out."

Develop specialized counseling or therapy.

Provide specialized interventions designed to help children process their feelings and cope with their experiences in non-clinical settings, such as the home or school.

"There is not enough affordable kids mental health. What is available is typically not from providers with specialized DV in children training."

"More resources are available for adults rather than specifically for children exposed to DV. Existing resources for children need to be marketed better or more child specific DV services need to be developed."

"Children in shelters should have a level of recognition of the impact of DV. They do need specialized services. They should have trauma services like what is available with sex abuse cases."

Help children learn that DV should not happen, and if it does, let them know it is not their fault.

"We need to educate children about what DV is and tell that it should not occur in families. People who have experienced DV should talk to the kids and tell them that it's not their fault."

"Better knowledge about DV will lead to more disclosures and therefore more interventions."

Work on DV education in early childhood rather than later or in adolescence.

"I think a lot of our work has been with dating violence instead of child witnesses to DV. We should be doing things for kids in kindergarten through sixth grade."

Provide adequate support for all family members.

"Both my parents felt very young and helpless when faced with raising a family. I think there are so many supports we would have benefited from."

"Children love their fathers too. Often abusers are seen as bad. But some victims want to try to make it work and aren't going to leave. They need services too. Also, (even for families that separate) children often continue to have a relationship with the father."

Suggestions for Communities: Help to prevent DV from happening in families:

Become involved, take responsibility, and work on misconceptions that DV is harmless to children.

"Communities need to be educated to step in and do something to intervene. Encourage the general public to make a stance and do something about it."

"We need to encourage more adults to be involved with the kids' lives. They need adults besides their parents that give the kids something their parents couldn't give them. Children are a resource that we all are responsible for."

Work on the attitudes, values and norms that perpetuate violence.

About a third of the informants said to change community tolerance of violence, and do not allow it as acceptable behavior. Community members need to educate, mentor, and role model appropriate behavior.

"We need a social-cultural value shift in our communities that will take a number of years. Even when some men say we shouldn't abuse women, they still do."

"We have to start early with men. It has to be modeled behavior. We can't be told one thing and shown something different. We need men mentoring that could do that work. You have to

start with the adults to reach the kids...We need education for adults to be role models and mentors for the kids."

For all, learn more about DV and how to safely help children and their families.

"Why don't people help? When someone has cancer you try and support them. With DV there is not enough out there to help you. Neighbors and community people need to be involved."

"Fund a public awareness campaign that DV is a problem for the whole family and impacts the children. The campaign should encourage intervention by the extended family and community."

"Teach people ways to respond to families like giving them scripts."

4.3 Key Findings from discussions with mothers whose children were exposed to DV:

Mothers were asked to talk about DV experiences with their families:

- ***Who knew that they and their children were living with DV***
- ***What others did when they knew about it***

About half of the informants reported that no one knew about their DV experiences. Other parents said that family members, such as the children's grandparents, siblings, and the abusive parent's family knew about their lives. A few informants said that family members were supportive and assisted with the care of their children.

Other informants reported that others outside the family, such as friends, neighbors or teachers were aware of what they had experienced. Sometimes nothing would happen when others found out about the DV. At other times, law enforcement or Child Protective Services (CPS) were called to intervene with the families. One parent talked to a teacher who provided support and wrote letters to document the DV and the abusive parent's behaviors.

Parent's experiences in seeking help/support for their children:

A few informants talked about positive experiences that they or their children had from neighbors, CPS, the police and a judge.

"My one son, he could escape during the DV to a family down the road. That family was functional. He could go there as much as he wanted and could stay overnight if he wanted to."

"My son dove out the window when my husband was beating me. He ran 250 yards in the snow barefoot to the neighbors to call the police. The police came for once and they took my husband away. Before that, they had always just told us to get along and went away."

"My daughter got hurt during DV so she was taken away from me by CPS. CPS did help me though and got me into shelter. It helped me to stop the abuse. "

"The judge allowed me to speak in court and held discussions in their chambers with only the lawyers to protect me. It was helpful when the judge was firm and had no patience for DV."

Many respondents reported that they were unable to ask for help/support because they were trying to keep the family together, were too overwhelmed and stressed, or were fearful of what would happen if they asked for support.

"What's in your home, stays in your home! This is particularly true for African American families. Two-parent families are less common and more prized among African Americans which made me more determined to make it work."

"I couldn't ask for help at times. My depression and post-traumatic stress issues kept me from asking for help. I knew I would be abused again by the systems and by anyone I talked to so I wouldn't ask for help."

"I didn't call the police because I didn't want my husband in the system. I didn't want to jeopardize his job."

"I didn't ask for help. I was too scared of what would happen."

Many respondents talked about the negative experiences they had in asking for help/support from family members or friends. One said that family members couldn't help as they had experienced DV themselves. Others described families attempting to intervene and making things worse or not providing help.

"My family tried to help but not in the best way. My brother tried to use physical force and tried to beat him up. My sister tried taking my kids away from me. I had stopped asking for help when the people I asked help from would help in the wrong way."

"My friends and family knew about it but they mostly turned their backs."

For those who reached for help outside of their families, most expressed that there were problems. Some asked for help from their church, courts, teachers, CPS, law enforcement officers, psychologist, supervised visitation provider, and school counselor. They were not supported as their information was minimized and/or dismissed, or they received a poor response with their disclosure.

"I told a pastor at church. He told me to be glad that I have someone to take care of myself and kids. He said that in front of him which made him feel empowered. I don't go back to church now."

"The courts gave more importance to both parents having time with the kids than helping the children's safety. This happened even with testimony from my family. The Prosecuting Attorney's Office knew about the DV. They took the stance of the batterer even when they knew about the DV."

"My child told his teachers about the DV, but the teachers were judgmental about me. All the teachers knew that my husband was beating us all up because my kids had bruises. CPS came out to my home three times. Each time the worker came to the home. They did not interview me and my husband separately. I tried to let the worker know I wanted to talk with him alone but he didn't get it. I couldn't tell him what was going on. They asked him if he was abusing the kids and he said no. They went away all three times and never did help with anything."

"One time they sent four white cops to my house. I didn't feel comfortable and I was afraid they would lock me up. I said forget it. They already knew I had DV. There were no female cops or black cops to help me."

"My son is seeing a psychologist, but in the past year his behavior has gotten worse and has escalated. The psychologist's suggestions are not sound. For example, he suggested I give my son time outs when he is getting angry, which is a bad technique because when he gets angry he becomes physically violent with me."

"Supervised visitation was meant to make it safe for my ex-husband to see the kids; however, he manipulated the chaperone into letting him doing things with the kids that were prohibited...he used the drop off period of the visitation to threaten me."

"I tried to talk with a school counselor. I had asked for some resources to go and get away from it and to help me come up with a plan. The counselor was not trained in that area and wasn't able to help me."

Parent's suggestions for helping children:

Work with children in schools. Schools are a safe place for children to talk about their feelings and experiences and learn information and skills.

Schools are the place where children spend much of their time. Schools are a potential venue for learning about DV, verbal abuse and control, and dating violence. They are the settings where kids can learn skills about effective communication, expressing feelings in a good way, development of healthy relationships, and conflict resolution.

"Have children's DV advocates go into the schools and do activities with all the kids in the classroom like art programs. They can teach all the kids about DV and how to recognize DV as an issue."

"Do groups with all kids in a grade school class to talk about what is happening at home. An outside counselor could come in and do it. Ask kids about their relationships with their parents."

"Make a video for kids up to about age 8 showing children or clowns doing rough behavior. Talk about basic norms around violence, hurting feelings and the impact. Give them information about the definition of abuse...Make sure kids' get two key messages: you're not at fault and you're part of the safety plan"

Utilize teachers as they are valuable resources.

Teachers can recognize the effects of DV and support children. They can promote non-abusive behaviors in schools and classrooms.

"Train teachers to be more supportive and promote self esteem with kids. Then kids wouldn't feel as vulnerable and would feel good about themselves."

"Teachers need to stop kids when they are being verbally abusive with one another. Bullying education needs to be expanded to include DV issues so it carries over into relationships in families."

Help children access good and supportive activities outside the home.

Informants would like their children to have positive experiences outside the home, such as participating in after school programs, tutoring, sports, movies, dance classes, music classes, camping, art activities, and theatre programs. They want their children to have opportunities to develop healthy relationships, a sense of normalcy, new skills, and improved self-esteem. Some parents also expressed a need help to finance these activities so their children could participate.

"Having activities and groups to belong to was important in keeping my daughter strong because it gave her a sense of normality"

Community providers need to learn safe and effective responses for children exposed to DV.

"We need education of ministers, teachers, counselors, and after school program staff. They can tend to panic and take things into their own hands. We need a protocol so they know how to respond and what to do, and how to address DV in a safe way... They should do more preventive care for DV like they do with well child check ups."

Provide professional support to children who need it.

Low and middle-income families need accessible and affordable counseling. They said that counselors, home visitors and case managers need specialized DV counseling skills.

"Giving therapy and outlets for expressing feelings are needed, as well as more services."

Give kids a safe place to talk about their experiences outside the family.

"We need DV support groups for kids so they can share their experiences. Half the time the kids are smarter than the parents. They take more in because they weren't in the fog."

"Have a website so kids could share what is happening to them, like a chat room. Or have a 1-800 number that is a place they can call that is a safe anonymous line."

Help parents understand and support their children's needs.

Informants expressed frustration, at times, in talking to their kids about the DV and would like to learn more so that they can support and help their children.

"Helping parents learn good boundaries with their kids. Not having healthy boundaries with our kids causes confusion. I have trouble with having good boundaries with my kids...sometimes I can be very angry with them and sometimes I treat my kids like I would a friend or buddy. The kids don't know where they are standing."

"Work with moms and kids together...Don't hide or lie to the kids. Also, sometimes we tell the kids too much and try to be their friends."

"My two-year old asked me: mom would you call the police on me like you did him? I need help to communicate with my child. Parents need to know how to get help."

Parent's suggestions for working with communities to prevent DV in families:

Parents reported that work should occur in communities to raise DV awareness, change community attitudes and norms about DV, increase competency and skills, increase the availability of culturally relevant DV messages and supports, and develop education/media campaigns.

Discuss openly that DV is not acceptable and that families should not keep it a secret.

"Men need to tell other men that locker room talk and glorifying violence is unacceptable."

"We need to do something about the Internet and TV programs that normalize violence."

"We need to change societal norms that encourage people to keep DV secret."

Work with media to provide community education and raise awareness.

"Need more education and resources for women that have kids. The help has to be louder than the DV, whether it is in commercials, busses or bathroom stalls. It has to be posted everywhere. I don't see it out there. We see television ads for depression, anxiety, smoking and alcohol. Sometimes people don't leave the home as they are isolated and they need to see DV on TV. Show signs of DV first, like his putting you down. Have the kids in the background crying and hugging a teddy bear and maybe show the kid calling for help."

"We need materials and advocates that represent different racial, ethnic and cultural backgrounds for credibility and so that people see that DV is not specific to any group."

Section Five: Surveys, Interviews, and Focus Groups with Community Providers

5.1 Safe and Bright Futures Stakeholder Meetings

Purpose: Stakeholders meetings were conducted to ask community members for their input on the strengths and weaknesses of the current approach to assisting infants, children and youth exposed to DV. They were asked questions about:

- Strengths and gaps of the current system serving children exposed to DV
- Improving providers' responses to children exposed to DV
- The level of community awareness about DV exposures on children

Recruitment: Project partners invited key constituents and community members representing health care, public schools, local funding organizations, social service agencies, local government, faith-based organizations, and DV agencies to participate.

Methods: The stakeholder meetings were conducted in north and south King County during June 2005. They were organized, facilitated, and documented by the Project Planner with assistance from the Design Team members. Meetings were approximately two hours in length. Forty participants answered questions by joining ad hoc focus groups, sharing ideas directly with Design Team and Project Planner, or recording responses on individual note cards or mounted posters.

Key Findings from Stakeholder Meetings

Strengths in existing services:

Participants reported that community based DV agencies' are providing supportive services to children and their parents. Some have play therapy, in-home therapy, counseling for moms on behavior patterns of children exposed to DV, and other parent support groups. Positive comments were made about specific programs including the South King County YWCA Children's DV Program, Kids Club (DV peer support group), Safe Havens Visitation Center, Youth Eastside Services (YES) programs, and support groups for parents whose children were exposed to DV. One participant shared the following example:

"I recently had a client who had a son about 9 years old who was very withdrawn, and I referred the child to YES where the counselor had training in working with youth and therefore used play therapy to build trust and rapport which worked very well. Within a month or so the youth was more outgoing, smiled more, and reported an overall improvement."

Gaps in existing services:

The following themes emerged in the responses about service gaps. The capacity of even the highly rated programs was limited. When people were unsuccessful in obtaining assistance, respondents noted these reasons.

Barriers in accessing services:

Parents who are DV survivors had difficulty in accessing services for a variety of reasons including safety issues, lack of transportation, poverty, high levels of crisis, and lack of housing. A few participants also mentioned there is a lack of substance abuse services and supports for families experiencing both DV and chemical dependency issues.

Lack of DV screening and training among mental health providers:

Almost one-third of respondents noted problems in responses from therapists and mental health counselors. This includes a lack of consistent screening for DV, not recognizing DV exposures in children, and therefore, misdiagnosing behavioral problems. It was stated that there is a need for more education and training for therapists and counselors about DV and its' effects on children.

Stakeholder participants' rating of the current system's capacity to serve children exposed to DV:

Participants were asked to rate current system capacity. Of the 25 respondents:

- 3 rated it unsure
- 14 respondents rated it non-existent to inadequate
- 3 rated it close to meeting need
- 5 rated it great

Stakeholder participants' suggestions for improving provider responses:

Participants offered the following suggestions on how to improve providers' responses to children exposed to DV.

Education and training:

The most frequently reported recommendation was to provide training to all professionals on understanding the effects from DV exposures on how to respond to children and families. Training should be provided to public school staff including teachers, secretaries, counselors and principals. Training should also be provided other responders including law enforcement, mental health, courts, and social services providers. As one participant stated:

“There is inconsistency in the levels of awareness of DV among the various systems that may intervene in the lives of children and families impacted by DV. This inconsistency contributes to widely divergent responses to these children and families.”

Improve services by increasing cultural competency:

Culturally competent responses and/or culturally specific responses and services are needed for DV survivors and their children, especially for refugees, immigrants, low English proficiency, gay, bisexual, lesbian and transgender, and the hearing impaired survivors.

Utilize a holistic approach that addresses DV concerns for the entire family:

Participants reported that DV affects not only the children's mental health, but their family's stability. Families do need help to support their basic needs and overall family functioning. As one participant explained:

“If mom leaves home, children's schooling may be interrupted. Unstable housing affects their friendships, etc. It goes well beyond the negative impact of observing DV. We need a coordinated system that serves all needs.”

Supporting the supportive parent's safety will keep children safer:

Participants reported that without increasing the safety of the parent, it would be very difficult to keep their children safe. Any interventions for the child must include approaches that promote the safety of the DV survivor, as the following participant stated:

“When the mother is supported, the child will be supported. This is not widely known or widely accepted by the general service population.”

Provide parenting supports to strengthen and/or repair the parent-child relationship:

DV survivors often experience severe and prolonged distress from relationships with abusive intimate partners. This often leads to disruptions in the relationships between the DV survivor and their children. Parents who are DV survivors need support and guidance on how to rebuild or develop improved connections with their children.

Stakeholder participants' rating of communities' awareness about the effect of DV on children:

Participants were asked to rate communities' awareness. Of the 26 respondents rating this question:

- 4 rated it unsure

- 15 rated community awareness as low
- 6 rated it medium
- 1 rated it high

5.2 Safe and Bright Futures Advisory Group

The Safe and Bright Futures convened a quarterly advisory group throughout the project period. This group was comprised of approximately fifty members from childcare, children and family services, schools, human services and government of our suburban cities, a number of researchers and academic professors with our local universities, juvenile court, prosecution, law enforcement, DV providers, mental health providers, and other services. The Advisory Group members were asked to give their input on the problems DV and children face, problems with existing services and providers' responses, and problems with communities' knowledge and responses. The following is a summary of their responses.

Some key problems DV survivors and their children face:

- Many DV survivors do not access community services and supports as existing services are limited in scope
- Immigrant DV survivors fear of deportation. They often lack of knowledge of immigration laws.
- Many DV survivors fear what will happen when they ask for help which may affect their ability to reach out to community services.
- DV survivors fear losing custody of their children (this was mentioned specifically for African-American families)
- DV survivors and children need validation and support of their DV experiences
- Lack of financial support. No support for the parent means there is no support for child.
- Children often cannot access DV services themselves.

Problems and gaps with existing services:

- Programs should be available to meet the needs of cultural and diverse communities. More culturally specific services and interpreter services are needed.
- Address the inconsistencies in practices, documentation, and referrals. Develop some sort of best practices guideline that is circulated and adopted.
- Need better early detection and screening for DV in systems including schools and health care
- Providers' caseloads are too big. Often providers' services are not long-term and can't address what families need.

- Need more well-trained therapists for quality intervention
- More accessible education and support groups for children exposed to DV and their parents
- Need more services for children ages birth to five
- Need better coordination of existing services and improved interagency relationships
- Need to clarify documentation and confidentiality policies among providers
- Need more services focused on rehabilitation and recovery, and not just correction and punishment
- Several problems in utilizing court and legal systems:
 - Court system at times is unclear and confusing for DV survivors
 - At times DV perpetrators do have joint decision making and they can veto or impede access to needed services for their children
 - Lack of affordable legal representation

Increase community members' knowledge and appropriate responses:

- Train everyone about DV in families and how to safely respond.
- Educate the public, especially employers about DV. Employment policies do not support victims and they have to quit their jobs.
- Teach children/youth exposed to DV how to develop their own support networks.
- Increase primary prevention activities in communities to stop the cycle of DV.

5.3 Professional and Community Providers, Key Informant Interviews and Focus Groups

Purpose: Professional and community providers were asked to respond to questions about:

- Existing services and service gaps
- Improving professional services and responses
- Information and activities that are currently available
- Future needs to support children and families

Recruitment: Project partners identified and referred professional providers from social work, mental health, healthcare, youth and family services, law enforcement, court services, education, children protection and child welfare, education, childcare, and DV advocacy fields. A total group of 65 providers participated in interviews or focus groups. This was a convenience sample group and may not be representative of the larger community.

Methods: A similar process was followed that was described earlier to develop the focus group/interview tool with the advice and consent of community partners, project assessment team and the evaluation consultant. Focus groups and individual interviews were conducted

from August 2005 - January 2006 and ranged in length from 1-2 hours. Notes were taken during each session, recorded electronically and kept on a secured database. To maintain confidentiality, no names or any personal identifying information was recorded. After two pilot interviews were completed, assessment team members and the evaluation consultant reviewed the material to ensure that it adequately captured the desired information. Data were analyzed at mid project and project end to identify themes and key quotes and shared with project partners for review and feedback.

Key Findings from Provider Interviews and Focus Groups

Existing services and supports for children exposed to DV and their families:

It was reported that there were a limited number of existing programs that provide effective supports to children, and there were significant gaps in their capacity to serve children. There were a few specialized programs for children identified, including the South King County YWCA Children's DV Program, Kids Club support groups, DV agencies based children's advocates, and the Safe Havens Supervised Visitation Center. Other identified helpful programs and supports included mental health services, DV education and parent support groups, Family Court Services DV and Parenting Plan Assessments, DV advocacy programs, specialized DV units in some responding agencies, and other general community supports and resources. Basic needs programs were also identified as essential for children and their families' well being including the DSHS Basic Food Program, financial and medical assistance, and community based DV shelter and transitional housing programs.

Gaps in existing community services and community supports:

Providers identified stumbling blocks or 'brick walls' that prevent kids from getting the services that they needed centered on one theme.

Lack of specialized services for children exposed to DV.

Approximately half of providers reported a lack of programs to which they can refer children. There is a need to expand advocacy, direct services and other supports tailored to the diverse needs of children. It was reported that families are not aware of programs and need assistance to connect to them. They also mentioned that many services are short-term and families need longer-term services and supports.

"There are not many services specific to kids exposed to domestic violence. There are only 2-3 in King County that I know of and there are long waiting lists."

Lack of culturally relevant services.

Approximately half of providers noted that services should accommodate the cultural and language needs of the children and parents who are accessing DV services and supports.

"Non-English speaking victims need more and better translating services so we can improve the way we serve these victims."

Limited access to effective mental health services.

The following problems were cited:

- There are limited available mental health providers who have the expertise in working with children exposed to DV.
- There are only a few mental health providers that can target interventions to children from birth to five years old.
- Families lack sufficient resources or medical insurance benefits for mental health services.
- It is difficult to qualify children for mental health services. Children must have significant symptoms that meet diagnostic criteria.

Not enough programs to help families heal and build supportive relationships with each other.

Most providers reported that supportive parents need guidance on how to talk about their DV experiences with their children and on how to strengthen their relationships.

"There are no services directed to improve or support relationships between the adult victim and child. There needs to be an improvement to or support of the dyadic relationship between the victim and the child."

Not enough opportunities for children to learn and talk about DV.

Schools were referenced as settings where all children could learn about and discuss DV.

"We need to normalize the DV experience in the school systems especially in the elementary level. We need to make it comfortable for the child to disclose."

"Curriculum for kids that explains and helps kids identify what is and is not okay in regards to DV, and to support the kids to be safe emotionally in a home with DV."

More children DV support groups are needed.

It was reported that children need to talk with other children about their experiences in sensitive and supportive environments that promote healing.

"Children need support groups – to promote socialization as well as seeing there are other kids impacted by DV – that they are not alone."

Engage children in informal support networks.

About a third of providers spoke about the need to strengthening children's natural support networks and getting them into healthy activities. This is important to break their isolation, enhance their strengths or protective factors, and help them deal with DV exposures.

"The literature points out that the impact of DV on kids varies. There is a differential impact. Children most need activities that promote resiliency. A smaller population of children requires trauma services."

"We really need to beef up informal networks of people that are already in kids' lives and will continue to be in kids' lives. It doesn't seem like these informal networks have been made enough of a priority. We need to make these networks a priority and support them."

More basic needs support services for families.

Significant wait lists posed problems in accessing shelter services and long-term housing. There was a lack of follow up for families seeking crisis services, thus impairing their ability to utilize other community resources. Transportation problems, particularly in suburban and rural areas, were a significant barrier in accessing services. About a third of providers indicated there are few low cost legal services for mothers and children.

Increase availability and improve services for battering parents.

About a quarter of providers reported that more services were needed for abusive parents. More work was needed to help DV abusers understand the effects of their abusive behaviors on their children, and to engage them in making plans for keeping their children and families safe. There should be greater access to effective supervised visitation services, such as those found at Safe Havens Visitation Center.

Strengths and Gaps with Professional and Community Provider Services

Service strengths:

Providers were applauded for making progress in serving children exposed to DV. About a third of providers reported that there had been progress in increasing communication, collaboration and coordination among providers and agencies. A third of providers reported that there had been efforts to ensure consistency, for example, the new law enforcement DV documentation forms and guidelines. Not reported as significant, but noteworthy, is the fact that more local DV research has improved opportunities for providers to learn about evidenced-based practices.

Service gaps:

Numerous service gaps were identified and recommendations for improvements are as follows:

More providers need to recognize and understand the effects of DV on children.

The majority of respondents reported that there are significant gaps in understanding the dynamics of DV within the family and how it affects the children. More information and training is needed for providers, and on-going training should be provided in agencies where there is high staff turnover.

"There is not currently a minimum standard of knowledge amongst providers about what is happening in DV affected homes and what help is useful. This is needed."

"There are gaps on understanding the effects/problems that DV perpetrators have on children. They don't know how perpetrators use kids to exert control/power and how they use children to manipulate situations/emotions."

More DV screening is needed when families seek and initiate services.

Providers overwhelmingly expressed a belief that screening children for exposure to DV should be done consistently at the point of entry and across professional disciplines. Guidelines should be developed for this process.

"Sometimes providers are not aware that DV is happening. They may see concerning behaviors with the children but don't know what is causing it, particularly when the youth becomes violent with parents and others."

Need more thorough DV assessments.

The vast majority of providers emphasized that when DV exposure is identified there should be thorough assessments of the exposure and its effects, the child-parent relationship, and what supports or services the family utilizes. Providers also needed training on using appropriate DV assessment tools.

"Pediatricians, counselors and other health providers may know there is DV but they are not doing a good assessment of it. Therefore the health provider's response is not based on needs of kids and is more of a "Cookie Cutter" response."

Need more training to effectively respond to children and families.

We need to build expertise of providers so that they may effectively support and respond to children and families. Providers also need tools and guidelines on how to assess a family's readiness to take action, and how to provide supportive messages to DV survivors and their children.

"Each provider in all disciplines that interface with families is responsible for knowing about DV and taking the role of the first responder with supportive messaging and services. People who talk to their providers about DV need to be responded to appropriately. A provider's role is not just to screen and refer a victim to a support group or other service. Providers need to respond with supportive messaging. It's not one person's job to fix this problem. If we all got clear that we have a responsibility to talk to our families about this issue, ask some questions, and provide supportive, empowering messaging...this is the most important thing we could do."

"Ensure (that) providers practice with standardized protocols so it is not so hit or miss."

Increase communications, coordination and collaboration among service providers.

Approximately half of the providers reported a need to better coordinate services. It was suggested as a central access point for referrals be developed and a resource guide of services and resources be developed for children exposed to DV.

"Services are in silos, duplicative, sometimes contradictory, lack of collaboration and communication between agencies providing services to the same family."

Develop consultation services with local DV experts.

It was reported that providers could benefit from having a professional consultation group to review and discuss DV issues as well as discuss beneficial interventions/services for these families.

"Who is there to consult with? There is not a good network to problem solve on cases. DV is a situation that needs consultation to keep kids safe."

Community: Existing information and efforts

About a third of respondents reported that there have been more public discussions about DV and children at conferences, local trainings and health fairs. About two-thirds felt that these efforts should be expanded.

"There is a lot of information out there. In the past 10 years, this has become an issue people are looking at. There is not a lot of information about the impact of exposure to domestic violence on children, and how to assess for and mitigate the effect of this exposure. King County had a good run of getting information out into the community about domestic violence. There is always a need to get more information out there."

About one quarter of providers reported that there were programs that got people involved, such as the King County Safe and Bright Futures Project, the DV and Child Maltreatment Coordinated Response Guideline Project, and the DV/CPS Collaboration Project and Best Practices Work Group. These initiatives and projects are helping communities to organize and take action.

Community: Recommendations for DV Intervention and Prevention:***Provide community education campaigns.***

Approximately half of the providers reported that media portray only severe DV cases. Go beyond the sensational cases and campaign with messages in newspaper articles, radio and television announcements, brochures, educational videos and electronic messaging. Develop and tailor unique messages to diverse populations.

"A lot of information is out there – what makes 'the news' is case like Brame, homicides –the extreme. Often sensationalized aspects of DV stick in people's minds...this not the whole story. For those living with emotional abuse and verbal abuse – they are pretty invisible."

"A bigger educational campaign is needed – we're always focused on women – how about one that focuses on impact on kids."

Focus on prevention efforts in the schools.

"Increase integration of DV training into school curricula – maybe an hour a year where kids come to understand through repeated supportive messaging what DV is, what to do about it,

where to get help. Repeat training every year. Let's not overburden the school system. Provide trainers from community partners to come in to do the training."

Involve more men.

A quarter of providers reported that it is important to get more males involved to take action to end DV.

"Men (and boys) need more information on taking responsibility and taking action to end DV."

"Get men involved. Encourage messaging like, 'It's okay to be a nice guy.'"

A call for leadership.

Providers suggested that community leaders should be recruited to become champions for children. Community champions could be instrumental in several ways by:

- Helping to raise awareness about DV in the lives of children
- Engaging their constituents and other community members to become involved
- Stimulating the development of programs and activities
- Leveraging needed resources

5.4 Safe and Bright Futures Providers Survey:

Purpose: The purpose of the survey was to gather input from community providers who did not have the opportunity to participate in the needs assessment project. Therefore, the project team surveyed participants attending a November 2005, King County Children and DV Conference. Survey questions were designed to capture providers' perspectives in three main areas:

- Strengthening responses to individual children and families
- Enhancing professional provider responses
- Increasing community awareness.

Methods: The survey was completed by a voluntary, convenience sample method of 71 respondents, and, therefore, may not be representative of all providers serving children.

Findings:

• Recommendations to help Individual Children and their Families:

Schools:

The majority of respondents stated that working with local schools was essential to creating an understanding and awareness of DV among children. Specific strategies included adding content to the curriculum about DV, teen dating violence, healthy relationships, conflict resolution, problem solving, communication skills, and non-violence. School support groups for DV exposed children and teens were seen as potentially helpful. Early intervention programs could be housed in schools and used to screen, identify, and refer children to appropriate services. Role playing healthy relationships was another suggested strategy.

Counseling and therapy for children and youth:

The majority of survey respondents reported that mental health treatment was essential in helping some children and youth work through the healing process.

DV education for individuals and families:

Approximately half of respondents reported that DV education was needed so that parents can have the skills to talk with their children and foster healthy relationships.

Support groups:

Provide children and youth with DV peer support groups.

Relationship skills training:

Provide education in schools and youth programs on the development of healthy personal relationships.

Bolster informal supports as the first line of defense:

Provide positive role models, emotional support, and empowerment for children. Provide children with trained community mentors. Encourage more community members to get involved with DV exposed children.

Churches and faith based services:

Churches or faith based services were cited as potential places to access and engage children and their families. They also can be utilized to provide services and supports.

- **Recommendations to Improve Professional Providers Responses:**

Training:

The majority of responders noted that quality, accessible training should be provided to professionals in schools, child care centers, healthcare, social work, law enforcement and the courts. Their training should include identifying the signs of DV, understanding the affects of DV exposure on children, how to assess for DV affects, and how to treat children. It was suggested to provide information and support to professionals through online newsletters and include summaries of recent research findings and evidenced based practices.

DV screening, assessment and referrals:

Develop protocols for DV screening, DV assessment, and referrals. This would improve the consistency and appropriateness of responses among providers.

- **Recommendations to Improve Community Responses**

DV campaigns:

The major recommendation that emerged with the survey responses was to develop a community media campaigns with public service announcements to raise awareness and get more people involved for exposed children and their families.

Section Six: Discussion

There were a number of **challenges** in obtaining data for this report. There are no available statistics that documents the incidence or prevalence of DV exposure with King County children. Therefore, the prevalence estimates in this report was based on national studies. The only DV data that is collected for this population is service delivery information gathered by some providers and system responders. Many agencies providing support and services to children exposed to DV do not routinely keep statistics on their services. For the systems based providers that do collect some level of service data for this population the information was often not readily accessible or easily shared. In order to gather information about the needs of children exposed to DV for this report, various methods were employed including surveys, stakeholder meetings, interviews, and focus groups.

The **strengths** with this SBF needs assessment project were that it was planned and implemented in collaboration with the project's community partners. With this community process data was successfully identified and gathered from multiple sources through multiple methods. Information was gathered from varying perspectives and levels within the county including input from governmental institutions and agencies, community providers serving the population, and individuals experiencing DV. The key issues and concerns identified across these groups overlapped and there were similarities in findings across all the individuals and groups who participated in the needs assessment project. Findings of this project are also consistent with other local and national reports.

Key findings from King County service data

- **The number of children with DV exposure is significant:**

Per national estimates the numbers of King County's children exposed to DV is significant. There is a high incidence of DV in high-risk families served by Child Protective Services and Family Court of the King County Superior Court, yet few children are receiving assessments and interventions for their DV exposures. Much work is still needed regarding consistent and comprehensive assessment of children's needs.

- **Access to services is not uniform across the county:**

The highest proportion of children (43%) lives in South County, followed by East County, Seattle and North County. South County has highest number of single parent households with limited economic resources and supports. In South and East County where the need is great based on population and there are more unincorporated or rural areas, there is limited access to services and resources due to fewer numbers of agencies and transportation barriers.

Key findings and recommendations made by DV Survivors and Professional Providers

The needs assessment project collected information by three main areas: individuals and families, professional providers and community. This section summarizes the key findings by each of these areas.

For Individuals/Families:

- **Families experiencing DV are isolated:**

Those DV survivors who participated in the needs assessment project reported that they are often isolated from other family members and friends, as well as to supports and services outside the family. Mothers reported that it can be difficult to address DV, especially when the abusive partner still resides with the family. For those who did access outside supports, there were problems in how systems and providers responded to their concerns with the information they received. There is much work that needs to be done in our responses to these families.

- **Children and families living with DV need help with basic needs:**

It was readily identified that many families accessing care would benefit from a wide range of services to meet their basic needs, particularly long term housing options, transportation, and legal assistance. DV survivors also identified that they often have a lack of financial and transportation resources that prohibits their children from participating in community programs like sports, camps, tutoring, and other activities where they may interact with other children and supportive adults.

- **Children need a wide range of services and supports:**

Community providers and DV survivors both identified that children have varying experiences and therefore, need a range of service and supports. Services and supports that are offered to children and their families should be based on a good assessment of the child and family's needs, engages and involves the supportive parent, are flexible and adaptable to the family's needs and willingness to participate in services. It was identified that services need to be culturally and linguistically appropriate.

- **Children need opportunity to talk about and process their experiences:**

Children's isolation can prevent them from understanding and normalizing their experiences. Peer support groups with other exposed children, individual therapeutic approaches, mentoring

programs and providing information/discussion in school settings are ways for children to process their experiences.

- **Children exposed to DV must be reached in earlier stages of development:**

Providers and parents both reported that there are little available services for young children birth through five years and early elementary ages. By reaching children earlier, supportive parents could be engaged in identifying their children's responses and needs, and strategies could be employed to strengthen the parent-child relationships. Young children's misconceptions and misunderstandings about their experiences could be modified thus leading to improvements in their well being, coping, and relationship development. When children's DV experiences are adequately assessed, evaluated, and supported, it can alleviate social and behavioral problems and school difficulties.

- **Children and parents need help to develop safety plans:**

Several providers reported that children need information and support to develop safety plans, even when the abusive parent is no longer living with the family.

For Professional Providers:

- **DV training is needed:**

Professional providers and DV survivors identified that all those who provide services to families need more education and training on the dynamics of DV in families, and the affects of DV on the children and families.

- **Providers need to screen for DV and know where to refer for services:**

Responding providers should provide DV screening for children and their families. Providers also need to know how and where to refer children for in-depth assessments, services and other community supports. There needs to be better availability and linkages to the programs that are designed to help this population. Resource guides need to be developed to facilitate better connections among service providers throughout communities. There also needs to be better coordination of existing services so that services can be accessed throughout the county, and for those with limited resources.

- **Build DV expertise and competency with providers:**

All service providers should increase their skills in responding to DV. Mental health providers were cited as one group that would be a priority for developing a specialized DV training process. This process would include training on:

- The use of standardized assessment tools which identify children's emotional and psychological concerns. Assessment tools should evaluate relationship concerns between the supportive parent and child, relationship problems with children's peers and community, children's strengths, DV safety risks, and family's access to supportive networks and community programs.
- The development of appropriate service plans which incorporates family strengths and ameliorates potential safety risks.
- Response guidelines for providing effective information, supportive messages, services and referrals.

For Community

- **Raise community awareness about children and DV:**

One of the most consistent themes that emerged regarding community efforts for children was the need to develop information campaigns to raise awareness about children exposed to DV. Providers and DV survivors reported that there is not enough information being disseminated through the media, television, radio, printed resources and posters. In addition, community members should have a basic understanding of how to safely approach and support families experiencing DV.

- **Mobilize community members to get involved:**

Involve more people, both men and women, in working to end DV throughout our communities. Supportive adults, such as teachers, coaches, ministers, Big Brothers/Big Sisters, can provide positive role modeling and mentoring to young boys and girls. Mentors can challenge and discuss negative attitudes and behaviors that perpetuate abuse and violence. It was also proposed that community leaders be recruited to serve as champions and become spokespersons on this issue in order to stimulate other community members to become involved and take action.

- **Develop and implement DV prevention activities:**

There needs to be more activities targeted to the prevention of DV throughout the lifespan. This could be achieved through providing education about DV, teaching about difficult feelings and conflict, and healthy relationships. DV prevention efforts also need to incorporate strategies to effect change in social norms and values that reinforce and perpetuate the use of violence and abuse.

Appendix A

Evaluation of King County Sheriff's Office (KCSO) training project for officer response to children present at a domestic violence incident

A total of 93 KCSO officer reports were identified from the time period of January 1, 2005 through March 31, 2005 and were included into the evaluation sample. To be included into the study sample a KCSO officer must have responded to a DV call, or took a report on a violation of a protection order, or took a report on a prior DV incident. In addition, the responding officer must have submitted an incident report and DV supplemental report which contained documentation that children were present at the DV scene. The following table is the demographic information recorded about the children present at DV scenes in the 93 KCSO reports¹³. A total of 138 children were present at the DV scenes.

Demographic information recorded by officers for children present at DV scene:

Number of Children in a Family Present at DV Incident (N=93)	Sex of Children (N=138)	Ages of Children (N=138)
56 families with 1 child	80 male children	59 children birth through 5 years of age
24 families with 2 children	55 female children	37 children 6-11 years of age
10 families with 3 children	3 children no information	33 children 12-18 years of age
1 family with 4 children		6 over 19 years of age
2 families no information		3 children no information

The responding officers also recorded other information in their reports about the children including their location during the DV incident, if there were active court orders in place, and if weapons were present or in possession of the perpetrator. Officers documented the children's location during the DV for 123 children (89%) of the 138 children.

The officers documented where children during the DV incident. The following locations were documented from most represented to least represented locations.

- Different room in the residence (35%)

¹³ Greenleaf, Deborah (November 2005). Summary report of the evaluation of King County Sheriff's Office training project for officer response to children present at a domestic violence incident. Report available through King County Department of Community and Health Services, Community Services Division, King County Women's Program.

- Sleeping or in their bedroom (29%)
- Same place or location as the DV incident (25%)
- No information (11%) was available.

Officers documented about whether or not protection orders were in place. They documented:

- In the majority or 71 cases (76%), no court orders were in place.
- In 16 cases (17%) were court orders identified
- In 6 cases (6%) no documented information about court orders

Officers also documented the presence of firearms.

- In the majority or 66 cases (71%) no weapons were reported by the victim to be in the home or in possession of the perpetrator
- In 19 cases (20%) weapons were reported in the home or in possession of the perpetrator.
- In 8 cases (9%) no information was recorded about weapons.

The officers' reports were also reviewed for documented safety risks or abuse/neglect risks posed to the children from the DV incident, and evidence of criminal charges.

- 75 reports (81%) of the sample did not have documented safety risks to children in the report. In 74 of these cases defendants were charged with misdemeanor crimes including Assault 4, violation of an order, interference with DV reporting, reckless endangerment, vandalism and criminal trespass. With this group there was only one felony charge for a no contact order (NCO) violation. (Note that in this NCO case the child was not listed on the order, thus this case was not included in the sub sample of children with child abuse or neglect risks.)
- 18 reports (19%) of cases had documented safety risks for the children, and 12 of these cases involved misdemeanor crimes as listed above. In 6 reports the officers recommended the filing of felony charges. When the 18 reports with identified child safety risks were reviewed by KCPAO attorneys, felony charges were filed in 8 cases (44%). The felony charges including felony harassment, felony threats, and Assault 2-with other deadly weapon. The documented child safety risks in these 18 cases were as follows:
 - Perpetrator threatened victim or child with a deadly weapon or displayed deadly weapon in child's presence
 - Child present in room when perpetrator threatened to kill victim or child
 - Child caught in crossfire (was held in victim's arms during the assault)
 - Child/youth was assaulted when intervening to stop the violence
 - Perpetrator assaulted child/youth during DV incident
 - Reckless endangerment (child in room where objects being thrown, perpetrator driving recklessly with child in the car)
 - Perpetrator violated a child's NCO

Appendix B

2004 Child Protective Services Data

In King County the Division of Children and Family Services (Region 4 DCFS) Washington State Department of Social and Health Services (DSHS) provides Child Protective Services (CPS). The units that respond to referrals of Child Abuse and/or Neglect (CAN) are located in five offices. The King West Office provides services throughout much of Greater Seattle. The King East office serves East King County from Mercer Island to Snoqualmie Pass and from Renton to the Snohomish County border. The King South Office serves South County families and has the largest area of urban and rural unincorporated communities. There are two offices that provide CPS to families living throughout King County. The Office of African American Children Services provides services to African American families and The Office of Indian Child Welfare provides services to Native American families.

Cases referred to CPS are screened for CAN risks. Cases may be screened as no risk of CAN or "Information Only" and/or "Third Party" referrals. These cases are entered into the CPS database to record the referral information.

Cases may be screened as "low risk" or "moderately low risk" for CAN. These referrals do not receive a response from a CPS social worker. They may, however, be referred to the Alternate Response Service for supportive family services or be sent a letter only that CPS received a referral and was not taking action on it.

CPS routinely collects data on the number of CPS intake referrals that are screened as "low risk" or "moderately low risk". The following table summarizes referrals made to CPS in 2004 that were not accepted for investigation by risk level and CPS Office.

CPS Office	Low Risk	Moderately Low Risk	Total
King East	69	216	285
King South	63	339	402
King West	60	166	226
Indian Child Welfare	8	43	51
African American	42	113	155
Total Across Offices	242	877	1,119

*2004 King County CPS low risk and moderately low risk referrals
not accepted for investigation*

Cases called into CPS intake may also be screened as “moderate”, “moderately high”, or “high risk” and are referred for CPS investigation. Referrals are assigned a Risk Tag and a Response Time at Intake based on the severity of the allegations made and other risk factors. The range of CAN risk tags and response times includes “Non- Emergent” or “Emergent” referrals.

Non-Emergent referrals are moderate and moderately high risk cases. A Non-Emergent referral is one in which a child is not at risk of serious and immediate harm. In 2004 the timeline for face-to-face contact with all child victims has been ten working days from the date of the referral. Effective August 1, 2005 the timeline for Non-Emergent referrals is now 72 hours from the date and time of the referral.

Emergent referrals or high risk case is one in which a child is at risk of serious and immediate harm. In 2004 the timeline for Emergent response was to begin the investigation within 24 hours from the date and time of the referral. Effective April 29, 2005 the timeline for face-to-face contact with all child victims on Emergent Referrals is 24 hours from the date and time of the referral.

CPS routinely collects data on the number of CAN intake referrals that are accepted for CPS investigation. The following table is a summary of referrals accepted for investigation and sent to the five CPS offices described above for assignment to a CPS social worker for case investigation. It is important to note that more than one child can be involved on a CPS intake referral. Of the 5,215 cases that were accepted for investigation, a total of 7,845 children were listed on these referrals.

2004 CPS Intake Referrals by Severity of Reported Abuse/Neglect Risk	
Moderate Risk	2,324
Moderately High Risk	1,561
High Risk	1,330
Total Number 2004CPS Referrals	5,215

2004 King County CPS Referrals accepted for Investigation.

Appendix C

*Issues and needs of children exposed to DV among ethnic groups**

Issue	African American	Amharic-Speaking (Ethiopian)	Cambodian	Filipina	Latina	Native American	Russian	Vietnamese
Beliefs and concerns about Domestic Violence (DV) with children and families								
Belief that DV is the woman's fault			X	X				X
Belief that divorce is detrimental to the family			X				X	X
Belief that mother must endure DV to protect children from scandal					X			X
Belief that "marital conflict" is normal, not a problem								X
Belief that children are better off with a father	X		X			X		
Concern for children's well-being if they leave the family & children stay with abuser								X
Mother's decision to leave is based on concerns that the DV affects/harms children	X	X			X	X		
Concern children view abuse as normal and continue the pattern in their adult relationships	X	X	X	X		X		
How DV affects children and their families								
Neglect, economic deprivation, and/or isolation - women and children are dependent on men for necessities and lack access to support and resources		X	X				X	
Fear that children will be harmed or killed	X							
Children experiencing DV directly in attempting to defend their mothers					X			
Abuse by other family members, further perpetuating idea that abuse is normal						X		
Abuser threatens to deport mothers & children							X	
Needed Service Improvements								
Need help getting child support		X						
Need help stopping abusive partner from having contact with children and families			X			X		
Need more shelters and housing assistance						X		
Need more language support in court					X	X		X
Need for shelters to provide more child services and emotional support	X				X			
Victim-blaming from counselors (with regard to parenting)	X							
Fear of CPS involvement making situations worse and need help negotiating the system	X			X	X	X	X	

Issue	African American	Amharic-Speaking (Ethiopian)	Cambodian	Filipina	Latina	Native American	Russian	Vietnamese
Service and support needs of children and families								
Children need counseling that is affordable and culturally sensitive	X		X			X	X	
Children need more education about DV and healthy relationship development	X	X		X		X		
Families need for safe and healthy neighborhoods without gangs and drugs in which to raise children		X				X		
Families need childcare assistance	X	X			X	X	X	
Mothers need guidance on how to best help their children			X		X			
Children need healthy activities such as recreation, field trips					X	X	X	X
Children need support and peer groups				X		X		X
Women's ideas for helping other women								
Self-esteem building - setting a good example for their children	X							
Need for education and information	X		X		X	X	X	

* Appendix C summarizes issues and concerns about children and their family from: Senturia, K., Sullivan, M, and Ciske, S. (November 2000). *Cultural Issues Affecting Domestic Violence Service Utilization in Ethnic and Hard to Reach Populations*. Report available through www.metrokc.gov/health

Appendix D

Interviews or Groups with:

Adults who had been exposed to DV when they were children

Parents whose children have been exposed to DV

Let's start by talking about your experiences. Please tell me which one of these experiences you would like to talk about in this interview (select one):

- ☐ Adults who had been exposed to DV when they were children
- ☐ Parents whose children have been exposed to DV

FOR ADULTS EXPOSED TO DV WHEN THEY WERE CHILDREN ANSWER 1A THROUGH 3A:

1. A. Were people you came into contact with (for example teachers, clergy, health care providers, friends or other family members) aware that you were living with DV as a child? If others did know about the DV, what did they do?
2. A. Please tell me a story about yourself as a child when you tried to get support or help for the DV and you received the help you needed. What made it work?
3. A. Now, please tell me a story of when you tried to get support or help for the DV and you were unable to. What went wrong? What didn't work for you?

FOR PARENTS WHOSE CHILDREN HAVE BEEN EXPOSED TO DV ANSWER 1B THROUGH 3B:

1. B. Were people your child came into contact with (for example teachers, clergy, health care providers, friends or other family members) aware that your child was living with DV? If others did know about the DV, what did they do?
2. B. Please tell me a story of when you tried to get support or help for your child about the DV and your child received the help they needed. What made it work?
3. B. Now, please tell me a story of when you tried to get support or help for the DV and you were unable to get the help your child needed. What went wrong? What didn't work for you?

Ask Questions 4 through 7 to all:

4. What do you think would help children who are exposed to DV? What needs to be made available in communities for children exposed to DV?
5. What would you do if you were given \$500,000 to help children exposed to DV?
6. What do you think is needed in our communities to prevent DV from happening in families?
7. That's all the questions I have to ask today. Is there anything else that comes to mind you'd like to share with me before we finish?

Appendix E

CONSENT FORM

Purpose of the Consent Form

This consent form will help you decide whether or not to participate in a discussion group or interview about children and domestic violence. This is not a research study. You may ask questions at any time about the purpose of the discussion group or interview, what we will ask you to do, the possible risks and benefits, your rights as a volunteer, and anything else about this project or form that is not clear. When we have answered all your questions, you can decide whether or not you want to participate in the discussion group or interview.

What Will I Have To Do?

If you agree to participate in the discussion group or interview, you will be asked questions about your thoughts and experiences. You are free not to answer to any questions you do not wish to answer. The discussion group or interview will last approximately an hour and a half.

What Are The Risks Of Participating?

You may feel uncomfortable talking about your personal experiences in the discussion group or interviewer. If it is upsetting and stressful for you to talk about your experiences with domestic violence, you may stop your participation at any time.

What Else Do I Need To Know?

Participation in the discussion group or interview is completely voluntary. The information you provide to us will be kept confidential and your name will not be connected to any of your responses. This means that anything you tell us about specific individuals will not be told to anyone unless you say it's okay. However, if you reveal unreported child abuse or risk of imminent harm to others or yourself, we are required to report this to the state authorities. In the discussion group, we will ask participants to protect each other's confidentiality by not to sharing any information discussed within the group after they leave. The project staff will keep your name on a list of participants. This will be kept separate from the data gathered during the discussions and interviews. Discussion groups and interviews will be taped or notes will be taken. Transcripts will be analyzed by project staff for key points and common themes. All recordings or transcripts and participant lists will be stored in locked files and will only be accessible to project staff. This information will be destroyed at the conclusion of the project.

Deborah Greenleaf, RN, MN

Project Coordinator

Date

Signature of Project Coordinator

Participant's Voluntary Consent Statement

This consent form and the discussion group or interview has been explained to me and all of my questions have been answered to my satisfaction. I volunteer to take part in this group or interview and understand that my participation is voluntary at all times.

Initials of Participant

Date

Appendix F

Key Informant and Focus Group Questions for Providers

Individual & Family:

1. Thinking about what you know about the current systems serving these children, what do you think is working well in the community? Which services are successful in helping children exposed to DV?
2. Now let's talk about what's not working so well. What are the stumbling blocks or brick walls that prevent them from getting the services they need?
3. What services do they need that are just not out there at all or are so under-developed or under-funded as to be inaccessible to those who need it the most?

Community Development & Mobilization:

4. Thinking specifically around this, what information is available in communities about children and DV? What information is not available?
5. Where do people go for information or support about children and DV?
6. What is happening in communities for youth or adults to get involved and take action on this issue? What should be happening?

Professional Provider Response:

7. Thinking about what you know about the current system of providers serving these children, what do you think is working well in the community? Which services are successful in helping children exposed to DV?
8. Now let's talk about what's not working so well. What are the stumbling blocks or brick walls that prevent them from getting the services they need?
9. What services do they need that are just not out there at all or are so under-developed or under-funded as to be inaccessible to those who need it the most?

Now I would like to ask you about your visions of what support or services you would like to see made available for children exposed to DV.

10. Pretend you have been asked to prioritize the most essential services for children exposed to DV. You will have the authority to fund the top three services. Which three services do you believe are most critical to receive funding?
11. If you were given \$500,000 to develop a program specifically designed to help children exposed to DV, what would it look like?
12. That's all I have to ask today. Is there anything else that comes to mind you'd like to share with me before we close?